NEWSPAPER

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Update

General Re, AIG will invest in two Bermuda cat facilities

STAMFORD, Conn.—General Re Corp. and American International Group Inc. are investing in two new Bermuda-based catastrophe reinsurance facilities.

General Re's board last week approved a $100 million investment in Tempest Reinsurance Co. Ltd., which is expected to have total capitalization of up to $500 million. According to sources, investor Donald Kramer, who just resigned as chairman of NAC Re Corp., is organizing Tempest Re and will serve as its chairman. Mr. Kramer

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Ruling is setback for managed care

Insurer PPO can't bar providers: Court

By CHRISTINE WOOLSEY

RICHMOND, Va.—Employers and insurers are decrying a federal appeals court ruling they say undermines competition among health care providers and douses the ability to keep health care plan costs in check.

Overturning a lower court ruling, the three-judge panel of the 4th U.S. Circuit Court of Appeals ruled that Virginia's so-called any-willing-provider law prohibits insurance companies from selectively contracting with exclusive providers.

The panel also ruled that establishing a preferred provider organization constitutes the "business of insurance." Therefore, Virginia's law is not preempted by the Employee Retirement Income Security Act, as defendant Aetna Health Management had claimed.

The 4th Circuit's June 2 decision clears the way for plaintiff Stuart Circle Hospital Corp. to become a member of Aetna's PPO in the state.

Proponents of managed care argue that selective contracting is the cornerstone of managing health care costs. By striking deals with a limited number and type of hospitals to form a PPO, insurers and managed care companies are able to implement cost reductions in services for health plan members.

Other observers say the decision unfairly penalizes insurance companies that want to establish PPOs in Virginia, because it appears that non-insurance entities, like hospital organizations or third-party administrators, could set up provider networks without fear of violating the law.

Richmond, Va.-based Stuart Circle in April 1991 sued Aetna Health Management, the managed care unit of Aetna Life Insurance Co. of Hartford, Conn., for excluding it from a PPO formed in 1987 to serve the Richmond area. The hospital claimed Aetna's actions in setting up the PPO violated a Virginia statute governing the establishment of a PPO by an insurer.

Among other things, the statute says an insurer cannot "discriminate unreasonably against"

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Dingell takes regulators to woodshed for Miro fraud

By MARK A. HOFMANN

WASHINGTON—Carlos I. Miro was 1,000 miles away, but his presence was almost palpable in a U.S. House of Representatives hearing room last week as state insurance regulators attempted to explain how he'd managed to avoid detection by state regulators for so long.

Officials of the National Assn. of Insurance Commissioners repeatedly told the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations that they could not make excuses for regulators allegedly corrupted by Mr. Miro, whose fraudulent dealings helped bring about the collapse of Transit Casualty Co. and Anglo-American Insurance Co. of Louisiana (*BI*, May 24).

Rep. Dingell

Mr. Miro, who was sentenced last month to eight years and 10 months in jail after pleading guilty to 16 counts of federal wire fraud, had appeared before the subcommittee a few weeks earlier and claimed that he'd had nothing to fear from state regulators while he siphoned premiums.

The NAIC officials' comments came during the subcommittee's third annual hearing on the effectiveness of the NAIC's financial regulation standards and accreditation program.

A report on the subject com-

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Reinsurers give no quarter

Despite rate hikes for property lines, casualty still soft

By JUDY GREENWALD

Expect little change in reinsurance market conditions this year.

While property business, particularly catastrophe-related lines, has hardened to varying degrees, casualty reinsurance remains soft. And with most of 1993's contracts already booked, there probably won't be any significant changes in the market this year.

"In terms of the overall market, we don't see much of a change," said Paul Malvasio, vp and chief financial officer of NAC Reinsurance Corp. in Greenwich, Conn.

While the property market has improved, casualty is still "pretty consistent" with the situation in January, "with no real sense of change occurring" for both treaty and facultative business, he said. "My sense of things is we're going to go through a few more quarters" before there is any change, he added.

"At this time, except for property catastrophe rates and property business that is subject to catastrophe, I don't see any change," agreed N. David Thompson, president and CEO of North American Reinsurance Corp./Swiss Reinsurance Co. in New York.

"I have not seen any activity in the primary or the reinsurance market relative to casualty," said James E. Dwane, president and CEO of Prudential Reinsurance Corp. in Newark, N.J.

"Other than some geographi-

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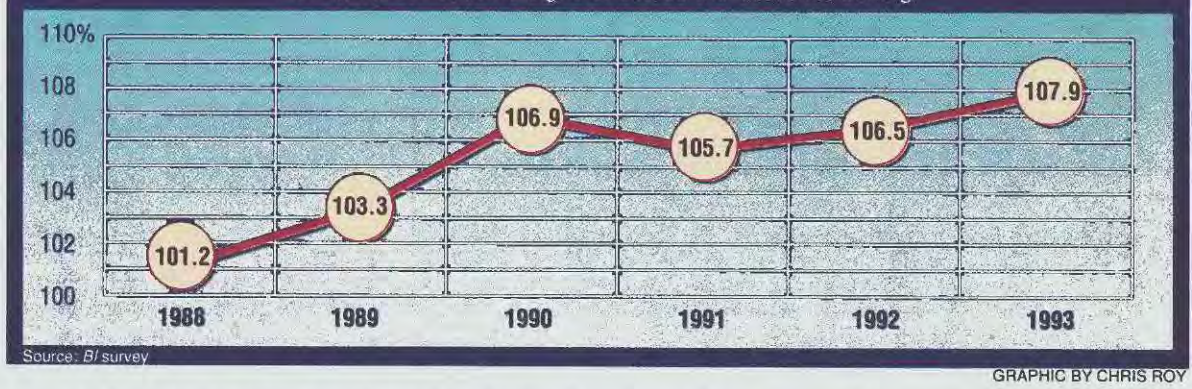
Up, up and away

Although U.S. reinsurers' combined ratio in the first quarter is at its highest in several years, the market still sees no signs of across-the-board hardening.



Source: *BI* survey

GRAPHIC BY CHRIS ROY

ADA rules to affect few health plans

By JERRY GEISEL

WASHINGTON—Most employers will have to make few, if any, changes to comply with federal guidelines explaining how the Americans with Disabilities Act affects health care plans.

However, the few employers that arbitrarily limit or deny coverage for specific diseases or conditions —like AIDS and HIV—likely will have to modify their plans to eliminate these restrictions.

The guidelines, issued last week by the Equal Employment Opportunity Commission as a policy statement, generally permit the most common type of benefit limitations found in health care plans.

"Many employers will find they will be in virtual compliance," said Mark White, a consulting actuary with The Wyatt Co. in Washington.

Coverage limitations, which the EEOC refers to as legal distinctions, would not be found discriminatory as long as they cut across a broad range of treatments and do not target a specific disability.

The EEOC is suing a self-insured multiemployer plan for refusing to cover HIV and AIDS treatment. Page 20

Examples of legal distinctions would include across-the-board exclusions for pre-existing medical conditions, limits or exclusions on coverage for experimental treatment or drugs, and lower coverage limits for the treatment of mental illness.

In addition, limits on coverage for medical procedures that are not exclusively utilized for the treatment of a particular disability would not violate the ADA.

For example, an employer could limit the number of X-rays or blood transfusions it will reimburse even though that kind of a limitation would adversely affect individuals with certain disabilities, the EEOC said.

But health care plans that single out a particular disability—like AIDS or schizophrenia—or a "discrete" group of disabilities—like cancer or kidney diseases—would be considered "disability-based" and thus discriminatory under the ADA, the commission said.

In such cases, employers would have the burden of proving that the limitations were justified and not subterfuge to evade the ADA.

The EEOC guidelines, which are effective immediately and apply to employers that self-insure their health plans as well as those that buy commercial insurance, offer a number of defenses—not meant to be definitive—that employers could use to prove that a coverage limitation was justified.

One defense, which benefit consultants say is somewhat vague and likely will lead to litigation, allows an employer to prove that the limitation is justified based on legitimate actuarial data or claims experience, and that conditions with comparable experience are treated the same way.

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Update

New catastrophe reinsurers

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could not be reached for comment.

AIG also is expected to be an investor in Tempest Re, said an AIG spokesman, who could not reveal the size of the investment.

Tempest Re is expected to contract with subsidiaries of General Re for certain underwriting and investment management services. It is expected to be operational by October.

Meanwhile, AIG Chairman and CEO Maurice R. Greenberg said at AIG's annual meeting last week that AIG will have a 25% stake in a new catastrophe reinsurance company that is expected to begin operations by the end of July. General Re is expected to be among other investors in this second facility, according to sources.

The catastrophe reinsurance facility is in addition to a new AIG excess casualty insurance facility in Bermuda that also is expected to begin operations in July (*BI*, Oct. 12, 1992).

In addition, Centre Reinsurance Holdings Ltd. has formed a shell company in Bermuda, dubbed Centre Cat, to explore options in the property catastrophe market. The facility has not been capitalized.

Florida raises Andrew estimate

TALLAHASSEE, Fla.—Florida Insurance Commissioner Tom Gallagher said last week that insured claims from Hurricane Andrew could reach $18 billion.

The insurance industry already has paid out more than $16 billion, the department says, estimating the total could be $2 billion higher.

However, the Property Claim Services division of the American Insurance Services Group has not revised its $15 billion estimate for insured property damage in Florida.

A.M. Best Co. has estimated that insured Andrew damage could reach $16.5 billion, including costs like loss adjustment expenses (*BI*, Dec. 21, 1992).

Pension adviser amendment

WASHINGTON—A Senate committee may vote this week to overturn a recent Supreme Court decision that protects pension plan advisers from being sued for monetary damages for allegedly helping plan trustees breach their fiduciary responsibilities.

A draft version of an amendment to the budget reconciliation package that would change the Employee Retirement Income Security Act of 1974 to allow suits against non-fiduciary advisers of pension plans circulated in Washington late last week. The draft, which Sen. Howard Metzenbaum, D-Ohio, is expected to offer to the Labor and Human Resources Committee this week, would permit suits against "any person who is not a fiduciary of a plan" who "knowingly participated in an act or omission of a fiduciary knowing that the act or omission was a breach of fiduciary responsibility of the fiduciary."

The U.S. Supreme Court on June 1 ruled 5-to-4 in the case of *Mertens et al vs. Hewitt Associates* that ERISA prohibited such suits (*BI*, June 7).

ABI rejects Pool Re rate hikes

LONDON—As the Irish Republican Army made two more terrorist attacks on the British mainland last week, the Assn. of British Insurers warned that insurers may pull out of the government-backed terrorism reinsurance pool if rates are increased with July 1 renewals.

Proposed Pool Re rate increases ordered by the government would be as high as 300% for the highest-risk area (*BI*, June 7).

On June 8, the day an IRA bomb exploded at a gas storage tank in Northeastern England, ABI Chairman Ian Rushton said in a letter to Michael Heseltine, Minister at the Department of Trade and Industry: "In future months it will be difficult to continue to maintain the active co-operation of the insurance companies in this venture."

On June 11, two days after the second bomb exploded—this one at a Northeastern oil terminal—an ABI spokesman said no reply had yet been received. Meanwhile, he said, the ABI, Confederation of British Industry, the Assn. of Risk Managers in Industry & Commerce and other parties will be "getting their act together" for the next stage in the disagreement. If no agreement can be reached, "insurers will apply the terrorism exclusion," the spokesman said.

ERIC seeks pension reform

WASHINGTON—Employers with underfunded pension plans would have to accelerate contributions under a proposal unveiled last week by the ERISA Industry Committee.

Benefit improvements for active employees working at companies with underfunded plans would be amortized over 10 years, while a five-year amortization schedule would apply for retiree benefit improvements. The faster funding schedule would apply for plan amendments adopted after Dec. 31, 1992.

Employers now generally have 30 years to fund pension liabilities.

The proposal also would make clear that employers in bankruptcy would have to continue to fund their pension plans.

The changes would better protect the Pension Benefit Guaranty Corp. from big losses and the agency may be able to reduce premiums it charges employers, the benefits lobbying group said.

Reinsurers awarded $37 million

BOSTON—A U.S. District Court judge has awarded $37.5 million to 34 foreign reinsurers after finding they were defrauded by three ITT Hartford Group Inc. units.

ITT Hartford units New England Reinsurance Corp. and First State Insurance Co. were to underwrite direct, facultative busi-

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Settlements mark progress in ELIC's long rehabilitation

By JOANNE WOJCIK

LOS ANGELES—The rehabilitation of Executive Life Insurance Co. cleared several hurdles last week when regulators negotiated settlements with policyholders representing nearly two-thirds of the insurer's unpaid liabilities.

However, large obstacles still remain.

A two-year feud between California regulators and Texas Commerce Bank came to an emotional end last week when the bank agreed to a settlement.

During a June 9 hearing on the state's newest ELIC rehabilitation plan, Los Angeles Superior Court Judge Kurt Lewin approved payment of $34.6 million to the bank, which served as trustee for a municipal bond backed by an ELIC guaranteed investment contract.

California regulators blame the bank and other holders of so-called muni-GICs for slowing rehabilitation proceedings (*BI*, April 26).

Texas Commerce Bank filed the original lawsuit challenging the Insurance Department's decision to relegate holders of muni-GICs to a status in the rehabilitation lower than that of other policyholders.

Under the settlement, the bank will withdraw its objections to the rehabilitation plan in exchange for an additional 1.4% of contract values to be paid by ELIC's successor, Aurora National Life Assurance Co.

Aurora also extended the 1.4% "bonus" as part of a settlement offer to other participants in the rehabilitation proceedings.

Holders of pension plan GICs and the Action Network for Victims of Executive Life, a group of individual policyholders, accepted the so-called "special settlement amount." In return, they dropped their objections to the

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Official details health benefits in Clinton plan

By JERRY GEISEL

WASHINGTON—Health care purchasing alliances, the centerpiece of President Clinton's health care reform package, would have to offer a choice of three health plans—a traditional indemnity plan, a health maintenance organization and a preferred provider organization—an administration official said last week.

White House Senior Domestic Policy Adviser Ira Magaziner provided the first details of the basic health care benefits package that would have to be offered to employees and individuals at a board meeting of the Health Care Leadership Council, a Washington-based group of 50 health care executives.

Many details, though, still are sketchy. Mr. Magaziner, for example, did not make clear whether employers that opt out of the purchasing alliances—assuming that is allowed—also would have to offer the three types of plans.

Mr. Magaziner, according to an HCLC official at the meeting, did indicate that the indemnity plan would have an an-

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Reform ultimatum

Rep. Cooper's support for plan hinges on managed competition

By JERRY GEISEL

WASHINGTON—President Clinton may lose a big block of Democratic supporters in Congress if his health care reform package veers too sharply away from managed competition.

Rep. Jim Cooper, D-Tenn., the leading congressional backer of managed competition, said last week that he has directed his staff to draft a health care reform bill.

If the Clinton health care reform proposal—now expected to be introduced in September—is "unacceptable," Rep. Cooper said he will be ready to introduce his bill.

When asked what would make a Clinton health plan unacceptable, Rep. Cooper said he was reluctant "to draw a line in the sand."

But speaking before the quarterly meeting of the ERISA Industry Committee, a Washington-based benefit lobbying group representing large employers, Rep. Cooper said the administration is considering a number of proposals that are at odds with managed competition.

Those proposals include the government setting limits on health care spending and forcing all employers into state-controlled health care purchasing cooperatives or alliances.

If Rep. Cooper does break away and introduce his own health care reform bill, it could be more than a loss of just one representative in the Clinton administration's drive to win a congressional consensus for its health care reform package.

Rep. Cooper is a key member of the Conservative Demo-

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Directory to list interactive benefit system vendors

Business Insurance will publish its first directory of Interactive Employee Benefit Communication Systems vendors in the Aug. 2 issue. This directory will accompany a Spotlight Report on benefit communication trends.

If your company develops and supplies proprietary interactive employee benefit communication systems directly to organizations for their employees' use, you are eligible to be listed.

To be included, companies must return a completed *BI* questionnaire by the extended deadline of June 25. There is no charge to be listed; the directory of vendors is published as an editorial service to our readers.

To obtain a questionnaire or for more information, call Directory Editor Kathy Welyki at 312-649-5279.

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Pollution ruling favors insurers

By MICHAEL SCHACHNER

WASHINGTON—The standard pollution exclusion in excess comprehensive general liability policies bars coverage for intentional waste discharge, even if the damage it causes is unanticipated and unintended, a federal appeals court says.

The ruling, which involves the notorious dioxin contamination of Times Beach, Mo., represents a rare insurer victory in a toxic tort coverage case before the U.S. Circuit Court of Appeals for the District of Columbia. At stake was more than $650 million in liability coverage.

Relying on a pair of 1989 decisions from New York's highest court, a three-judge panel affirmed a lower court ruling that, under New York law, a defendant cannot tap its excess liability policies to pay Times Beach-related claims.

Attorneys say the June 3 ruling, which involved 14 insurers, is important because:

• It sets precedent in the D.C. Circuit that liability insurance does not cover pollution unless the actual discharge or escape of a contaminant occurs in a sud-

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Breaking international barriers

Brokers, insurers mindful of global trade problems

By SALLY ROBERTS

SEA ISLAND, Ga.—Global trade issues—like the General Agreement on Tariffs and Trade and the North American Free Trade Agreement—are increasingly weighing on the minds of brokerage and insurer executives with global ambitions.

However, they also are carefully watching efforts to reform the Superfund law and the U.S. tort system.

"There's been a history of trying to break down barriers of trade," observed Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York.

"Trading partners recognize that if (GATT) is not successfully completed in 1993, the likelihood of failure is very great—and that is frightening," he said.

The current GATT negotiations, dubbed the Uruguay Round, addresses trade barriers affecting financial services, including insurance (*BI*, Oct. 19, 1992).

NAFTA, awaiting congressional ratification, would allow free trade of insurance services between the United States, Canada and Mexico (*BI*, Aug. 24, 1992).

"Latin America may be the most important growth market for U.S.-based operations," said Arthur F. Quern, chairman of Rollins Hudig Hall Co. in Chicago.

Executives from brokerages and insurance companies discussed global marketplace issues during two panel sessions at the National Assn. of Insurance Brokers annual conference in Sea Island, Ga., earlier this month.

Most executives agreed that words like "multinational," "international" and "global" are becoming cliches.

In fact, Mr. Greenberg humorously remarked that when people describe global operations as "seamless," they "sound like a bunch of tailors." Mr. Quern said the buzzwords will have "15 months of celebrity."

Nevertheless, many executives were in accord about the significance of globalization.

It's important to be truly global—like The Coca-Cola Co., McDonald's Corp. and Hertz Corp.—because there is a "consistent level of service" wherever the client might be located, said Ronald W. Forrest, chairman & CEO of Alexander & Alexander Inc. in New York.

At RHH, globalization is seen as a "commitment to clients" that they receive the best service and quality anywhere in the world,

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Vermont law opens door for captives to write employee benefit coverages

By MICHAEL SCHACHNER

MONTPELIER, Vt.—"If you offer it, they will come."

That appears to be the logic behind Vermont's decision to allow companies to begin writing employee benefit coverages, like health insurance, through their Vermont captives.

But will they come? Is Vermont ready to regulate captives writing group benefit coverages? And, most importantly, will the U.S. Labor Department relax a third-party business rule that has long made it difficult to insure benefits through a captive?

A bill signed into law by Gov. Howard Dean on June 4 makes Vermont the first state to take real steps toward allowing captives to directly write employee benefit coverages for their parent companies. But serious questions remain about whether the state will succeed.

The state's chief captive regulator and several Vermont-based captive managers say they are confident that captives will ultimately write benefit coverages.

But it will take time: Vermont initially will only allow employers to write group term life insurance through their captives. Disability and accident insurance will likely be the next coverages allowed by regulators.

Vermont initially is limiting captives to group term life insurance for two key reasons:

• The Internal Revenue Service ruled last year in Revenue Ruling 92-93 that employers can deduct group term life premiums paid to their captives. Thus, employers have an immediate financial incentive to write group life via an existing captive.

• Life insurance is relatively simple to write and regulate because benefits are paid predictably and evenly over time, and reserving is easier for this line than for health insurance.

But if regulators become comfortable overseeing group life, employers may eventually get the green light to write health insurance through their captives, said Leonard Crouse, director of the captive division at the state Department of Banking, Insurance and Securities in Montpelier.

"Our legislation was spurred by 92-93, which is a simple and clear ruling. Why wouldn't employers want to get a tax deduction for these premiums and at the same time avoid paying mar-

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Managed care taking off in work comp

By MEG FLETCHER and MICHAEL SCHACHNER

Employers, tired of waiting for workers compensation reform, are increasingly turning to managed care and other cost control measures, a survey shows.

As a result of the steps taken over the past two years, employers are more optimistic now that workers comp costs can be brought under control than they were two years ago, the survey reports.

Still, 17% of those surveyed in consultant Towers Perrin's second biennial workers comp cost study believe that rising workers comp costs threaten their financial results "a great deal," compared with 19% in 1991.

The consultant estimates that annual medical and wage-replacement costs for insured and self-insured employers will surpass $140 billion by the year 2000, compared with the current $60 billion, with medical costs accounting for nearly 50% of total costs.

Rising workers comp costs have motivated employers to "dramatically" increase their use of two dozen cost-containment initiatives in the past two years, some by as much as 150% to 200%, the survey reports.

"Workers compensation can borrow the cost management techniques like audits, preferred provider organizations, precertification and utilization review, that have worked well on the employee benefit side," said Jerry Miccolis, vp and the St. Louis-based leader of the firm's workers compensation consulting practice.

The trend partially reflects the increased willingness of states to expressly allow use of cost containment measures, especially managed medical care techniques (*BI*, March 8).

But "while state reform has helped, the credit must really go to employers who have gone on the offensive in controlling their individual workers compensation costs," Mr. Miccolis said.

For example, 50% of employers surveyed now contract with managed care networks for workers comp cases, up from 20% two years ago.

Other dramatic increases were reported in the number of employers that use case management, which increased to 84% from 30%; utilization review, which jumped to 70% from 28%; precertification of non-emergency medical treatment, which rose to 57% from 19%; and coordinated administration of workers comp and employee benefit claims, which rose to 39% from 17%.

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Hillary tops hubby as managed care VIP

The most important person in managed care is not a physician, or a health care executive, or a person with any medical training.

She is Hillary Rodham Clinton, and she is thought to be more influential than her husband, the president, by a more than 3-to-1 margin.

So say 130 managed health care executives recently surveyed by a specialty executive search firm and the American Managed Care & Review Assn.

Mrs. Clinton garnered nearly 37% of the vote, while Bill Clinton came in with a mere 11.7%, just ahead of the Jackson Hole Group's leader, Paul Ellwood, at 8.8%.

But, lest the First Lady think she has too much influence, 31.1% of the vote went to various write-in candidates.

Primary care physicians garnered 5.8% of the vote, while the consumer and Ira Magaziner, President Clinton's senior domestic policy adviser, got 2.9% each.

—By Christine Woolsey

Photo by AP/Wide World

Connecticut comp law praised by employers

By MARY E. PFLUM

HARTFORD, Conn.—Connecticut businesses expect to save up to $190 million this year thanks to a new workers compensation law.

Approved recently by the state Senate 32-4 and signed by Gov. Lowell P. Weicker, the law will require workers comp insurers to cut premiums by 19% and will substantially cut benefits for injured workers.

Connecticut regulators will implement the 19% rate reduction on July 1, the new law's effective date. July 1 also will become the renewal date for all workers comp policies in Connecticut; all policies previously renewed on Jan. 1.

Employers who have policies now in effect will receive credits on July 1. Employers that do not renew their work comp policies at that time will receive refunds for premiums paid on the remainder of the old policies.

Future workers comp insurance rates will be set based on how well the new law reduces costs. Proponents of the

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Virginia PPOs

Continued from page 1

providers that are willing to meet the insurer's terms and conditions.

The hospital claimed Aetna did not include it in its PPO not because the hospital couldn t meet its standards, but because it was not a member of Aetna's existing health maintenance organization in Richmond.

The district court proceedings centered on the pre-emption provisions of ERISA, which increasingly are being challenged on the state level in matters concerning health care reform (*BI*, Sept. 28, 1992; Sept. 14, 1992; June 1, 1992).

Stuart Circle's attorneys argued that the Virginia statute does not "relate to" an employee benefit plan and, even if it did, the state law regulates the "business of insurance" and therefore is not pre-empted by ERISA.

Aetna countered that the Virginia law does relate to employee benefit plans and thus is pre-empted by ERISA. The insurer also contended that the law was not designed to regulate the "business of insurance."

The 4th Circuit agreed with the district court's ruling that, contrary to the hospital's arguments, the statute does relate to employee benefit plans.

However, the appellate court did not agree with the district court that setting up a PPO is not the "business of insurance."

In the appellate panel's opinion, Senior District Judge Richard L. Williams cited a Supreme Court ruling involving ERISA's so-called insurance savings clause, which was designed to prevent ERISA pre-emption of state laws governing the business of insurance.

"To borrow the Court's phrase, a 'common-sense view' of the Virginia statute discloses that it regulates certain insurance contracts, albeit indirectly through the structure of a PPO," Judge Williams wrote.

Setting up a PPO is not the business of insurance, says attorney William Jeffrey Kilberg.

Aetna hopes the full circuit will overturn the panel's decision, said William Jeffrey Kilberg of Gibson, Dunn & Crutcher in Washington, who represented Aetna.

Setting up a PPO isn't the business of insurance because it does not regulate the relationship between the insurer and the policyholder, he said. "There is no reason to believe you are affecting the coverage people get" by setting up a PPO. "What you are affecting is who delivers the service, not the services delivered."

In addition, he said, the ruling is faulty because it doesn't affect hospitals or TPAs that set up PPOs, since the statute only regulates insurance companies.

Nine state legislatures have passed laws that restrict the operation of managed health care plans in some form. If the 4th Circuit ruling holds, "many more states will probably adopt" similar laws, Mr. Kilberg predicted.

However, employer groups and insurers say they will continue to vehemently oppose such laws.

"The appellate court's decision isn't correct," said Curtis Rooney, a legislative associate with the Assn. of Private Pension & Welfare Plans, an employer lobbying group in Washington.

"Any-willing-provider statutes don't serve competition," said Anthony R. Masso, director of managed care and insurance products for the Health Insurance Assn. of America in Washington. The laws "are just a defense mechanism for hospitals to keep some business short-term. They are usually submitted by local medical societies saying, 'We are being excluded and it's hurting business. Protect us.' "

"At the state level, provider groups are seeking to protect themselves from the reality that in some areas there are too many hospital beds. And they want a piece of every PPO," Mr. Kilberg said. "Unfortunately, when everyone gets to participate, we hinder competition. When you negotiate a PPO, you say to the hospital, 'We'll provide an economic incentive to patients to come to you. In exchange, we want. . .a reduction in normal fees.' Hospitals do this because they expect the volume."

If insurers or managed care companies allowed all hospitals to participate as network providers, they would lose any negotiated fee discounts arranged with selected providers, he said.

"I disagree that price advantages are diluted," said Philip O'Neill, an attorney with Keck, Mahin & Cate in Washington who represented Stuart Circle.

Interestingly, Virginia's state hospital association approves of selective contracting as a necessary strategy to control health care costs. "The Virginia Hospital Assn. recognizes that selective contracting is an important piece of health care reform. Unfortunately, that means some of our members won't be chosen" to participate in some health plan networks, said Susan Ward, director of legal and regulatory affairs for the Richmond-based association. BI

BI adds reporter in London

LONDON—Adrian Ladbury has joined *Business Insurance* as an associate editor in the London bureau.

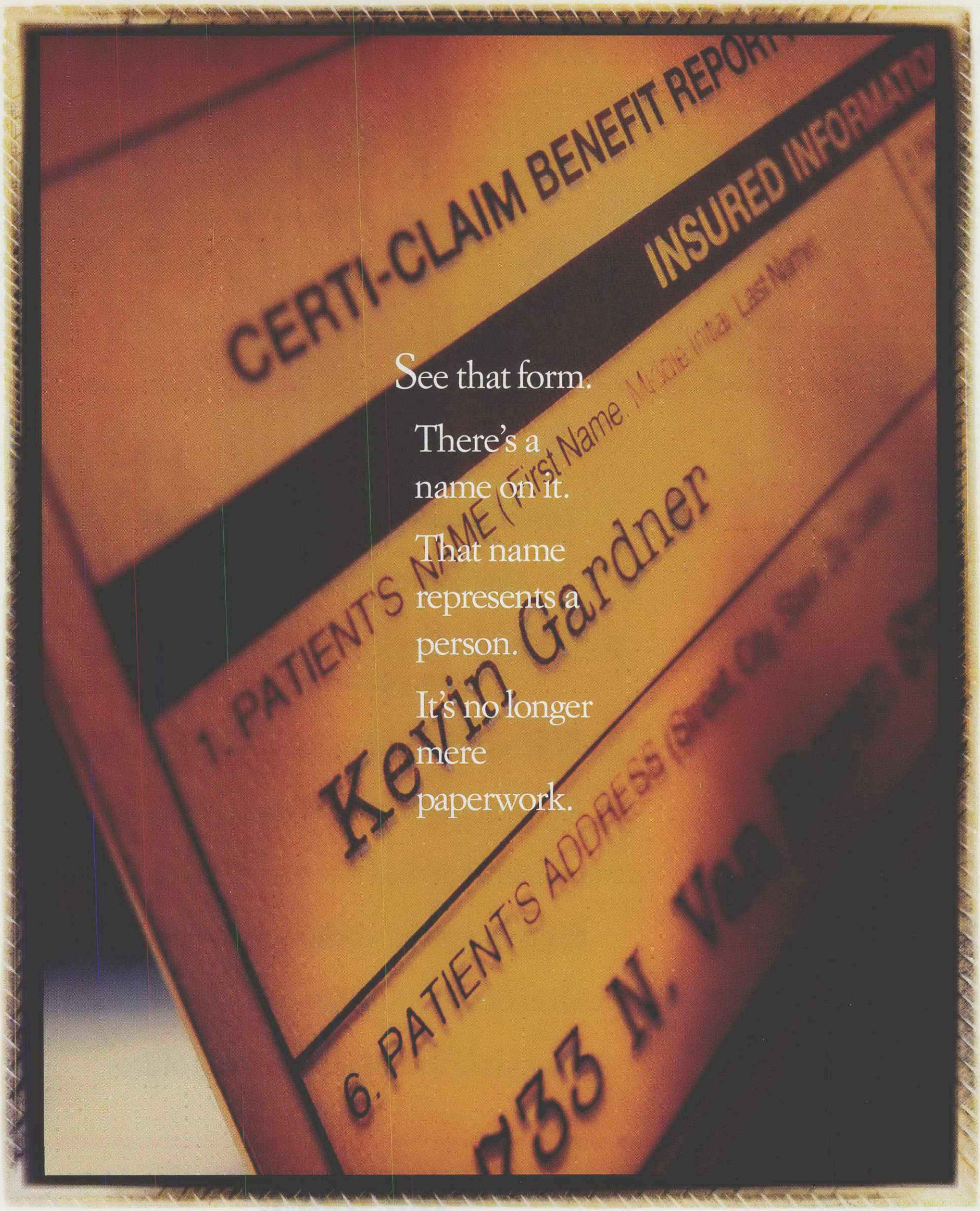
Mr. Ladbury, 27, replaces Associate Editor Gavin Souter, who recently transferred to *BI*'s New York bureau.

Mr. Ladbury

Before joining *BI*, Mr. Ladbury was both news editor at Post Magazine, a weekly U.K. insurance publication, and editor of Reinsurance, an international reinsurance monthly. Before that, he was a reporter at Insurance Age and assistant editor at The Review, two other London-based insurance publications.

Mr. Ladbury received a bachelor of arts degree in modern European history and politics from Queen Mary College at the University of London in 1987.

Mr. Ladbury will report on the London and continental European insurance markets. He can be reached at 071-608-1172. BI



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New financial aid program at Xerox

STAMFORD, Conn.—Xerox Corp. has entered the first phase of a career-long benefit program geared to help employees with work and family issues not addressed in the company's flexible benefits plan.

LifeCycle Assistance, which became effective in April, is a first-of-its-kind financial assistance program. It permits eligible employees to receive up to $10,000 in aftertax cash over the course of their tenure with Xerox to help offset family-related expenses like child care, and eventually elder care, college tuition and home mortgages.

The plan, which was developed jointly by Xerox and The Segal Co., is administered by Metropolitan Life Insurance Co. The plan currently provides only child care subsidies to employees earning less than $50,000 per year. However, in future years, employees will be able to apply for cash to defray other family-related expenses.

"This is a unique program to my knowledge," said Wendy Starr, manager of LifeCycle programs and policies. "The plan is designed to be flexible within the framework of family needs. Employees can use all of the $10,000 for child care or they can decide to save their money and use it for what they feel they need most."

Child care, she said, will likely be the only program for which eligibility will be based on salary.

"This plan came about because we wanted to make benefits as responsive as possible to changing employee needs. They now have a defined amount of Xerox-provided benefit dollars that they can use as they see fit," she said.

Ms. Starr predicted the child care subsidy will probably run by itself until the end of next year, at which time employees will be able to apply for assistance on paying a dependent's college tuition or for other needs.

"The only requirement is that the event and the need must be documented. That is why an application for assistance must be filed and approved," she said.

—By Michael Schachner

Suing over premiums

CHICAGO—Utility workers are suing Central Illinois Public Service Co., two of its officers, CNA Insurance Cos. and Towers Perrin, alleging the employees were fraudulently overcharged for health insurance premiums.

The defendants fraudulently readjusted employees' medical premiums so that the union employees were paying for part of non-union members' premiums, charges the suit filed as a class action in federal court May 26 by International Brotherhood of Electrical Workers Local 702.

The workers claim the company violated a labor agreement to hold family medical coverage to $75 per month. Several months after the union ratified the 1993 pact, CIPS raised those premiums to $179 per month, according to IBEW attorney Marilyn Teitelbaum of Schuchat, Cook & Werner in St. Louis.

The suit also claims that when workers refused to agree to the higher premiums, the company locked out 1,500 union employees to try to force their acceptance.

Ms. Teitelbaum said CIPS admitted the overcharges and has repaid employees over the past 15 months. But the workers still seek more than $4 million as redress for unfair labor practices.

Benefit Beat

A spokesman for the Springfield-based utility would not comment.

A Towers Perrin spokeswoman said the company could not comment because it has not seen the suit.

A spokeswoman for CNA said the company has seen the suit but cannot comment on pending litigation.

—By Christine Woolsey

Survey: GICs popular

Those who participate in 401(k) plans continue to favor guaranteed investment contracts over other, higher-yield options by a wide margin, a recent survey shows.

This indicates that 401(k) participants are investing too conservatively and running the risk of accumulating inadequate retirement income, according to the report, which was released last month.

Some 51% of total 401(k) assets are invested in GICs, according to a survey of 545 mid-size to large employers conducted by The Wyatt Co. The next most popular investments are: company stock, 26%; and index funds, 9%. The remaining types of investments, including equity growth funds, diversified funds and balanced funds, each represent 3% or less of total assets.

"Individually directed 401(k) accounts typically earn two to three percentage points less than large professionally managed pension plans," said Richard Joss, a Wyatt consultant. "That spread can mean the difference between a comfortable and not-so-comfortable retirement."

—By Nancy P. Johnson

Pact ends utility strike

BOSTON—Union workers for Boston Gas Co. have agreed for the first time to pay for a portion of their health care costs following a 17-week strike over copayments.

Eleven hundred members of two local United Steelworkers of America unions have agreed to pay a minimum of $2.06 per week for individual coverage and at least $5.76 per week for family coverage, depending on the health plan they choose.

In return, union members will receive wage increases ranging from 4% to 4.5% over the next six years, improvements in pension benefits and the addition of a 401(k) plan featuring a 25% company match for employee contributions, up to 6% of salary.

Previously, union members had received major medical indemnity coverage through a Blue Cross & Blue Shield plan (*BI*, May 17). Union members now will be offered a choice of four health plans: two health maintenance organizations—the Harvard Community Health Plan and Fallon Community Health Plan; a managed care program administered by the Prudential Insurance Co.; and HealthFlex Blue, a BC/BS point of service plan.

—By Deborah Shalowitz

Vermont captives

Continued from page 3

ket price for the product?" said Mr. Crouse.

"We're trying to be accessible to new ideas and I believe we're flexible enough to entertain and answer problems. That's why this legislation came about," added Ray Oberg, senior vp with M&M Insurance Management Services Inc. in Burlington.

Other captive experts also believe that the IRS granting favorable tax status to group life premiums paid to a captive should prompt employers to at least consider using captives for life insurance and other benefits.

"The only time it makes sense to put benefits into a captive is when it's cost-efficient. Something that's actuarially predictable, like life insurance or long-term disability, makes sense—especially if you can take a tax deduction," explained Kathryn Westover, senior vp with American Risk Management Corp. in Burlington.

"The idea of using captives for benefits has tantalized employers for years, but with ERISA barriers and alternative methods of writing benefits, very few companies have pursued it," said Henry Saveth, a benefit consultant with A. Foster Higgins & Co. Inc. in New York.

IRS ruling 92-93 may be the impetus employers need to move forward in this area, he suggested. "Establishing group life as third-party business for which premiums are tax-deductible has to be enticing to companies with captives in Vermont. The only thing to watch out for is that your sole motivation isn't the tax deductions. It has to be a good plan," Mr. Saveth said.

'The idea of using captives for benefits has tantalized employers for years, but with ERISA barriers and alternative methods of writing benefits, very few companies have pursued it,' says A. Foster Higgins & Co.'s Henry Saveth.

But even with the IRS ruling, Vermont still faces a major hurdle in its efforts to allow employers to write benefit programs through captives.

Under a 1979 Labor Department ruling, no more than 50% of the business of a captive writing employee benefit coverages can come from the parent company. The remaining portion, therefore, would have to come from third-party business.

As a result, companies would find it virtually impossible to meet the 50% rule and avoid violating the prohibited transaction rule contained in the Employee Retirement Income Security Act unless they write a high level of outside business, which Vermont's law would not allow.

To remedy this, the Vermont captive community and several lawyers are asking the Labor Department to declare a captive's non-benefit business—primarily property/casualty business—outside the 50% test.

For example, a captive that is writing $10 million in total business solely for its parent company, of which $8 million is in property/casualty premiums and only $2 million is in life and health premiums, would fail the current 50% test because 100% of its premiums would be generated by the parent.

But if property/casualty premiums were excluded from the formula, life and health benefits in this case would account for only 20% of the captive's overall premiums and the arrangement would pass the 50% test.

Beyond such a declaration, the only other way employers will get permission to use a captive for benefits is to seek individual exemptions from the 50% test from the Labor Department.

It is uncertain whether the department would grant such an exemption in this case, said Mr. Saveth.

Although Vermont's law will allow captives to insure most types of benefits, state regulators fear the volatility of health claims and will not allow the practice without further study.

"There's not a thing we can do with. . .health at this point," said Mr. Crouse. "No one has showed us a way to do it. It will take several more years of looking into it."

Others question whether captives will ever be used to fund group health benefits.

"I just can't see there being any interest to use captives for funding health care," said Jon Harkavy, vp and general counsel with USA Risk Group Inc. in Arlington, Va., parent of Vermont Insurance Management Inc. "There would have to be a prototype that comes along for others to follow. Nobody wants to be the first in."

"Group health is far too unpredictable for captives. Besides, most companies are already self-insured with ASO arrangements. They probably wouldn't want to move," said Ms. Westover.

Lastly, the question of whether captive owners will take advantage of the law and use Vermont captives to write benefits coverages still must be answered.

At this point, many employers with Vermont captives are just becoming aware of the new law, though one risk manager said the concept of using a captive for benefits is intriguing.

"We're very interested in the new legislation," said Lea Gerber, risk manager with Elixir Industries in Gardena, Calif., which owns GarDen Insurance Co. of Vermont.

"Although it's brand-new, the possibility of placing life insurance in the captive is great. It's so predictable that we could surely profit. On the other hand, I doubt we could handle health."

Other risk managers with Vermont captives said they are waiting for clarification of the 50% test as well as the unveiling of the Clinton administration's health care reform package before making a decision to explore captives for employee benefits.

"To be honest, we haven't even thought about it yet. We're just now looking at the legislation," said Gene Heskett, director of risk management with White Consolidated Industries Inc. in Cleveland, which uses its Vermont-based captive for property and casualty exposures.

"If the ERISA hurdle is cleared, maybe then we can move ahead," he commented. BI

Opinions

Don't lose the opportunity

A HEADLINE ON the editorial page of The Wall Street Journal last week proclaimed: "Dead on Arrival—Clinton Health Care Plan."

While we certainly do not want to believe that is the case, it is indeed clear that President Clinton's ambitious timetable for radically reforming the U.S. health care system has been thrown askew. The grand unveiling of the reform plan, scheduled for the beginning of May, was pushed back to June and now could come as late as September. We doubt that even Michael Jordan would be willing to bet that deadline will be met.

The delay, of course, is both a practical and political reality. It's now clear that no real consensus has been reached among administration officials, legislators and interest groups on many important parts of the plan. The White House still is trying to reach that consensus by floating trial balloons in the media.

That's good for us journalists, but it probably is not solid public policy.

Politically, the president cannot hope to shepherd a health care reform program through Congress until work is completed on his tax package. And, postponing the announcement of the plan was a wise response to critics who charge that President Clinton often bites off more than he can chew.

The delay could be both a good and a bad development. It will be good if the president and his advisers, including Hillary Rodham Clinton, will use the time to draft a program that will truly expand access to health care services while controlling costs for employers and other payers—without eliminating freedom of choice in choosing providers and health insurance financing mechanisms.

However, the delay will serve no purpose if it only leads to more confusion—on the part of the administration, the members of Congress who must approve any plan and the rest of America.

We're worried that confusion is occurring. Three months ago, many thought they knew the elements of the president's plan and were ready to work on its behalf; that's not now the case.

Many—like Rep. Jim Cooper—are worried that what had been billed as a proposal based on managed competition could be, in essence, a single-payer health care plan. They are urging the president to rethink the most controversial parts of his proposal, such as global health care spending caps and giving control over all employer-sponsored health plans to state-administered purchasing cooperatives (see story, page 2).

Others, though, like Sen. John D. Rockefeller IV,

are trying to bully business—albeit politely—into backing the president's proposal. Sen. Rockefeller said in an interview with *Business Insurance* earlier this month that if business does not back President Clinton's version of managed competition, they'll end up with a "British" health care system (*BI*, June 7).

In short, while the president's health care plan is not yet on the table—in fact, it's not even on paper yet—any consensus that he hoped to gather on health care reform is quickly evaporating.

The ball is solidly in President Clinton's court. How he handles it in the next several months will determine the future of the U.S. health care system.

Last year, we criticized President Bush for ignoring the critical problems in the health care system. When he finally did speak out on health care, he failed to back up his rhetoric with a complete legislative proposal.

President Clinton could fall into that same trap. We're worried that his pledge to take "bold steps to reform the health care system" this year could be yet another broken political promise.

As we suggested more than a year ago, only the president has the political clout to bring all players in the health care system together and forge a consensus on how the system can be reformed. If President Clinton wants to show he is indeed a leader—something that is very much in doubt right now in Washington and across the nation—health care reform would be a good place to start.

Letters

Simple work comp solutions hard to achieve

To the editor: I read with interest your May 17 article, "Reform Plan Takes Shape." In light of my quoted statement, I felt the necessity to elaborate on some of the difficulties in integrating workers compensation into a national health care system.

While this goal is certainly laudable, it is fraught with numerous difficulties.

In California, for example, a lot of money is expended on a medical evaluation system to determine whether or not an injury arises out of the employment and to determine the extent, if any, of permanent disability. The only way that I can see to have full integration of workers compensation and medical insurance in the state of California would be to do away with the whole medical evaluation system and allow the treating physician to provide a non-disputable opinion. (This solution would not only eliminate medical evaluation costs, but would also greatly reduce litigation.)

Unfortunately, this simple solution clearly is not politically feasible. If, however, this approach were adopted, then we would be left with only a few complex issues with which to deal, such as deductibles and copayments for medical care, which are not generally acceptable in workers compensation.

I do sincerely wish the Clinton administration all the best in their attempt to deal with a problem that has severely plagued business in this country for years.

Stephen M. Wilder
Assistant Treasurer-
Risk Management
The Walt Disney Co.
Burbank, Calif.

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Pollution ruling

Continued from page 3

den, accidental nature.

- It asserts that a disperser's lack of intention to cause damage does not override the exclusion.
- It clarifies that the exclusion applies even when a third party, and not the named policyholder, discharged the waste.
- It signifies that the D.C. Circuit, which is generally seen as an activist court willing to modify or reverse state court rulings, is willing to read state law narrowly when appropriate.

More immediately, it relieves a group of insurers—including U.S. Fire Insurance Co., a unit of Aetna Casualty & Surety Co.; Insurance Co. of North America, a unit of CIGNA Corp.; and 12 London market insurers—of their responsibility to defend and indemnify a Missouri-based petrochemical company and related defendants. Combined, they face federal, state and individual pollution liability and tort claims of about $12 billion.

"This case is very significant because it is the fist time the D.C. Court has issued a ruling on the pollution exclusion and it sends a signal to other federal appeals courts that it's proper to uphold the decisions state courts have issued in similar cases," said Michael Aylward of Morrison, Mahoney & Miller in Boston, which represented U.S. Fire.

Dennis Flannery of Wilmer, Cutler & Pickering in Washington, which represented INA, commented that the ruling brings the D.C. Circuit in line with many other courts' reading of the exclusion.

"This is a further advancement of courts across the nation accepting that the pollution exclusion means exactly what it says. If anything can be drawn from this case, it's that a trend is developing," he said.

Both lawyers caution that only policies governed by New York law are directly affected.

Cathy Serafin, an attorney with Anderson Kill Olick & Oshinsky in Washington, which represented Independent Petroleum Corp., called the ruling an "incorrect reading" of the pollution exclusion's true intention, which, she insisted, is to bar coverage for companies that knowingly pollute the environment.

"The purpose of this exclusion is to preclude coverage for intentional polluters. It makes no sense to deny coverage when there was no intention to pollute. In this case, there was clearly no intent to cause damage. Courts need to realize that this is not an intentional waste disposal exclusion," she said.

No decision has been made by IPC to request a rehearing before the full D.C. Circuit or to seek review by the U.S. Supreme Court, Ms. Serafin added.

At issue in this case were 18 excess policies written between 1981 and 1983 that were required to follow the form of an excess policy written by a captive insurer of the parent of IPC, which is the lead defendant in the pollution litigation. The captive's policy designated New York law as governing interpretation of the contact.

Hundreds of other primary and excess comprehensive general liability policies written for IPC and its parent, Charter Oil Corp., since 1971, are in litigation and unaffected by the ruling.

Yet the stakes were by no means small in the D.C. Circuit case. U.S. Fire wrote about $68 million in excess liability coverage for IPC between 1981 and 1983. INA wrote about $20 million over the same period. London insurers' aggregate limits exceeded $570 million.

"We're very pleased that a court that has not been shy about forming its own opinions despite what other courts have said chose not to second-guess the New York court. This isn't necessarily something they would have done in the past," said Mr. Aylward.

For at least five years after the D.C. Circuit's famous "triple trigger" ruling in a 1981 asbestos case, policyholders tried to have their pollution coverage disputes heard in this jurisdiction, he explained. In fact, a flood of coverage lawsuits involving DES, asbestos and pollution claims were filed in the wake of that decision, *Keene Corp. vs. INA*.

But the attorney who represented the London market insurers in this case said the D.C. Circuit may no longer be considered a pro-policyholder court.

"This shows D.C. is not going to interpret the laws of sister states in its own way. It's a decision we're very happy with," said Michael Nussbaum of Nussbaum & Wald in Washington. "I think the court's reputation has changed."

Meanwhile, the ruling in no way settles the morass of litigation IPC faces for its connection to dioxin contamination that occurred in portions of eastern Missouri in the early 1970s.

IPC is tied to the case because the independent contractor it hired in 1971 to remove 20,000 gallons of waste oil from a site owned by Northeastern Pharmaceutical & Chemical Co. later mixed that waste with waste materials from other sources and spread the mixture as a dust suppressant over a number of sites, including Times Beach.

That mixture was later determined to contain highly toxic dioxin. As the alleged effects of the dioxin became apparent to local residents, claims for bodily injury began pouring in.

Eventually, at least 57 civil suits involving more than 1,600 claimants were filed in various courts against IPC and related companies. The aggregate amount individual claimants are seeking totals about $4 billion for bodily injury and property damage and an additional $4 billion in punitive damages.

The company also faces lawsuits initiated by the state of Missouri and the federal government, which, in effect, purchased the town from residents after the contamination.

In ongoing coverage disputes, IPC continues to press the argument that the pollution exclusion does not apply in this case because IPC's contractor, Russell Bliss, had promised to dump the waste in a special site outside St. Louis, but instead released the mixture, not knowing it contained dioxin.

IPC argues that the fact that the waste hauler tasted the mixture and sprayed it on his own horse pasture was evidence that he knew nothing of its toxicity. IPC also contends that the dispersal was "accidental" in that IPC did not expect Mr. Bliss to spray the waste oil.

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Independent Petrochemical Corp. vs. Aetna Casualty & Surety Co., No. 92-5069, District of Columbia U.S. Circuit Court of Appeals, June 3, 1993.

Largest U.S. reinsurers' first-quarter 1993 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1993	Net reinsurance premiums written 1992	Policyholders surplus (reinsurers only)	Net income 1993	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1993	Combined ratio 1992
1. General Re	$547,993	$523,276	$3,555,322	$146,665	$393,317	72.8%	$185,165	33.8%	106.5%	105.4%
2. Employers Re	411,326	323,785	1,594,882	70,578	301,136	78.7	106,156	25.8	104.5	102.0
3. American Re	327,728	250,717	1,004,373	25,330	175,148	62.8	123,437	37.7	100.4	100.7
4. North American/Swiss Re	192,156	185,915	652,002	16,784	126,406	70.2	80,011	41.6	111.8	106.4
5. Berkshire Hathaway	172,190	186,833	N/A	N/A	87,275	124.7	9,448	13.5	138.2	172.4
6. Prudential Re	171,712	160,602	544,291	27,840	111,645	67.0	59,190	34.5	101.5	114.6
7. Munich Re	166,292	159,783	692,963	3,910	129,022	83.7	54,215	32.6	116.3	109.2
8. F&G Re	158,708	58,824	N/A	N/A	93,377	61.4	49,433	31.1	92.5	87.8
9. Transatlantic/Putnam	129,298	117,319	487,442	16,730	107,434	82.7	32,894	25.4	108.1	107.6
10. Kemper Re	104,610	148,654	339,183	10,697	121,222	87.5	31,947	30.5	118.0	106.8
11. Constitution Re	88,122	67,107	280,448	7,929	69,915	72.0	28,848	32.7	104.7	107.6
12. Transamerica Re	86,371	94,400	290,983	20,406	63,850	75.5	27,113	31.4	106.9	107.3
13. The St. Paul Cos.	80,321	85,036	N/A	N/A	86,410	101.3	25,630	31.9	133.2	129.9
14. National Re	78,706	58,024	336,388	17,102	49,740	66.1	27,232	34.6	100.7	100.3
15. NAC Re	67,034	55,041	395,922	12,179	44,218	68.7	28,201	42.1	110.8	108.5
16. Skandia America Group	52,956	87,893	311,857	7,735	75,254	87.8	17,544	33.1	121.0	111.7
17. Scor U.S. Group	51,589	50,446	264,780	8,450	34,573	66.7	20,662	40.1	106.7	95.3
18. Winterthur Re	50,243	53,151	167,859	4,944	43,184	81.4	13,077	26.0	107.5	108.2
19. Underwriters Re	42,343	34,522	185,360	8,512	32,968	80.4	11,194	26.4	106.8	106.0
20. PMA Re	40,306	39,471	217,411	9,311	16,125	86.6	9,016	22.4	108.9	111.8
Totals for Top 20	**3,020,004**	**2,740,799**	**11,321,466**	**415,102**	**2,162,219**	**78.9**	**940,413**	**31.1**	**110.0**	**110.8**
Total for all companies	**3,337,369**	**3,034,591**	**14,622,374**	**483,949**	**2,413,896**	**75.1**	**1,094,270**	**32.8**	**107.9**	**106.5**

Source: Reinsurance Assn. of America and *Business Insurance*

Reinsurer results

Continued from page 1

cally oriented property rate increases, the market, generally speaking across the United States, remains relatively flat. We continue to see rate competition, particularly in casualty lines," said Tom Case, chairman, president and CEO of Employers Reinsurance Corp. in Kansas City, Mo.

The lines that drove prices up in the last cycle were excess umbrella, specialty casualty risks, professional liability and long haul trucking, and "I have yet to see a single price go up in that area," said Paul Ingrey, president of F&G Re in Morristown, N.J., a USF&G Corp. unit.

Meanwhile, "People are—amazingly, in my view—still writing casualty reinsurance at depressed prices," and they probably will continue to do so in the absence of a major catastrophe, Mr. Ingrey said.

The U.S. reinsurance industry reported a 107.9% combined ratio for the first quarter, compared with a 106.5% combined ratio for the same period a year ago, according to a survey of 59 reinsurers by the Washington-based Reinsurance Assn. of America. This was an improvement, however, over the 119% combined ratio posted for all of 1992, which reflected losses from the worst catastrophe year on record (*BI*, March 29).

The 20 largest reinsurers, however, fared somewhat worse in the first quarter. They posted a 110% combined ratio, a slight improvement over the 110.8% combined ratio reported for first quarter of 1992. A somewhat different group of the 20 largest reinsurers reported a 117.9% combined ratio for all of 1992.

The top 20 reinsurers reported a 78.9% loss ratio in the quarter, compared with the 75.1% loss ratio reported by all the reinsurers. However, the larger reinsurers had a better expense ratio—31.1%—than all the reinsurers, which had a 32.8% ratio.

Net premiums written by all the reinsurers increased 10% to $3.34 billion from $3.03 billion, while the top 20 reinsurers posted a 10.2% increase to $3.02 billion from $2.74 billion.

Pointing to first-quarter results, Mr. Thompson said, "I would say it's unexceptional. It's not particularly surprising either way, neither good nor bad. It's not where we would like it to be, obviously."

"I think generally speaking across the board, they tend to reflect what I would expect to see knowing what has taken place so far this year," said Employers Re's Mr. Case, referring to this year's catastrophes, which have included the East Coast blizzard and World Trade Center bombing, as well as continued development of Hurricane Andrew losses.

The combined ratio for reinsurers is likely to remain at about 107% or 108% for the rest of the year, said Robert D. Hogue, an analyst with Firemark Consultants Inc. in Parsippany, N.J. "That would seem reasonable, in line with the rest of the industry," he said.

Reinsurers will remain conservative in their approach this year, he said. "They've been burnt really badly by Hurricane Andrew. I think they're going to probably pull in, become a little harder, not write as much, wait and see."

"I don't think you'll see impressive results this year" in either the reinsurance or the primary industry, said NAC Re's Mr. Malvasio. "Hopefully I'm wrong with all this, but I don't see it," he said. Absent significant storm losses, reinsurer results "should show moderate, but not dramatic improvement."

Even with moderate improvement, reinsurers will not get the returns they should be getting because of declining yields on their investments, he said.

Mr. Case agreed. Although what happens is "going to depend an awful lot on what happens from a catastrophe standpoint," assuming catastrophes are "normal" then "I think you'll see numbers continuing to improve between now and year end," he said.

"I think a lot of it has to do with where companies are in the lines of business that they write," said Pru Re's Mr. Dwane. Assuming no extraordinary catastrophes, reinsurers that write a diversified book of property business should do a little bit better than those writing strictly casualty, he said.

There will be "no dramatic changes insofar as reinsurer results are concerned" for the rest of the year, predicted John Snyder, senior vp at A.M. Best Co. in Oldwick, N.J.

This year is "basically done with in terms of pricing and booking the business," said Mr. Snyder. All that is left is the July 1 renewal business, and most of this business is already "well into the discussion stage of being priced and booked."

A 10% premium increase reported by reinsurers for the first

Continued on next page

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quarter compares with a 0.1% decline in premiums written in the quarter by the major property/casualty insurers surveyed by *Business Insurance* (*BI*, May 24). Net written premiums increased just 3.6% for the entire U.S. property/casualty industry, according to the Insurance Services Office Inc. and the National Assn. of Independent Insurers (*BI*, June 7).

The reinsurers' premium increase reflects "some shift beginning to occur" from the primary to the reinsurance market, said Myron M. Picoult, managing director and senior insurance analyst with Oppenheimer & Co. in New York. "Obviously, there's some adjustment of risk profiles happening."

NAC Re's Mr. Malvasio noted that while overall premium volume grew by 10%, some reinsurance companies—including American Re-Insurance Co., Employers Reinsurance Corp. and National Reinsurance Corp.—reported premium volume rose by more than 25% in the first quarter.

This could confirm the trend of a flight to quality, with insurers moving to "more secure, better managed and better capitalized" reinsurers, he said. NAC Re's 21.8% increase in premiums reflects both business booked last year and new opportunities this year, he said.

However, Pru Re's Mr. Dwane, whose company's volume increased 6.9%, said: "We're pretty close to what we've planned. I don't think there's any message in that."

The decision by Pru Re's parent to sell its reinsurance unit has not had an effect on Pru Re's business, he said. BI

Connecticut law

Continued from page 3
law predict that future rate increases will be 12% to 14% less than they would have been otherwise.

The new law will:

- Cut maximum weekly compensation for injured workers by about 21%—to $609 from $769.
- Cut average weekly benefits about 6%—to $309 from $327. The percentage of net pay replaced will be reduced to 75% from 80%.
- Repeal cost-of-living adjustments on benefits.
- Reduce the maximum duration of wage-replacement benefits to 520 weeks from 780 weeks.
- Restrict compensation for injuries incurred during voluntary work-related sports and recreation activities, or as a result of drug and alcohol use.
- Limit stress-related compensation to only those mental injuries that arise from a physical injury or occupational disease.

The new law is receiving a positive reception from members of the insurance and business communities.

Roger Thompson, director-commercial lines of Hartford-based Travelers Corp., said the new law will make Connecticut a better state in which to write workers compensation insurance.

"From a claims-handling perspective, this will improve the Connecticut insurance environment considerably. We view this as a very positive legislative move," he said.

A spokeswoman for Aetna Life & Casualty Co. agreed the state's workers comp insurers stand to gain from the new law, despite the rate cut.

"The workers compensation climate will certainly improve as a result of the law. It provides cost-saving measures for everyone," she said, adding that she hopes other states will soon follow Connecticut's footsteps.

Connecticut business leaders say they are confident the new law will significantly reduce workers comp costs and improve the business climate of a state maligned for being insensitive to business' needs.

"We think workers comp is a major business-climate issue. This package will help to retain existing jobs as well as attract additional jobs to the state," said Timothy Moynihan, president of the Greater Hartford Chamber of Commerce.

Bonnie Stewart, assistant counsel with the Connecticut Business & Industry Assn. in Hartford, called the package a positive sign that Connecticut is serious about working with, rather than against, business.

"The package is very significant because workers compensation is one of the most expensive aspects of doing business in Connecticut. This legislation will make Connecticut more competitive," she said.

For Eugene Calistro, risk manager with New Haven Manufacturing, the reform law comes as particularly welcome news. "I think the changes were long overdue. Compared to other states, Connecticut has such high workers compensation rates. I hope this will reduce the differences between our state and other states."

According to the National Foundation on Unemployment Compensation & Workers Compensation, profit margins posted by workers compensation insurers in Connecticut fell below the national average in only one year since 1986. During the other years, profit margins in Connecticut exceeded national averages by three to five percentage points.

Another factor plaguing Connecticut business is high claims costs. Connecticut had the highest average cost per work comp claim in the nation, while its maximum weekly benefits were among the nation's highest as a percentage of average weekly wages, according to the Boca Raton, Fla.-based National Council on Compensation Insurance.

Still, Connecticut employers have been better off than those in some New England states. According to a recent study by John Burton of Rutgers University, Connecticut ranked 13th in the nation for overall workers comp costs. Maine, Massachusetts, and Rhode Island all had higher costs.

Connecticut companies insist the new law is vital to efforts to reverse a downward business spiral in a state that has lost a reported 180,000 jobs in the past four years. Risk managers blame part of that slide on high workers comp costs.

"Prior to the reformation legislation, in many cases, the insurance costs for workers comp surpassed production costs. Now, we can be more competitive with neighboring states and Southern states," said Daria Cirish, director of risk management for Heublein Inc. in Farmington, Conn.

However, Ms. Cirish said that with the new law comes the chore of clearly communicating the positive components of the package to panic-stricken Connecticut workers.

That may be a tough sell. John Olsen, president of the Connecticut AFL-CIO, insists there are few, if any, positive aspects of the recent legislation. "We really feel that the savings will amount to $190 million worth of injured workers. Who's to say that these companies aren't going to take the money and run off to another state?"

Rob Bradford, corporate director of risk management for the Olin Corp. in Stamford, says the cutbacks will benefit all Connecticut citizens in the long run, however.

"A lot of the state's companies, including ours, are feeling the recession hard. Anything to cut costs is a positive. In the past, we were looking outside of the state. This is just one more thing to make us look to stay in Connecticut in the future," Mr. Bradford said. BI

Global concerns

Continued from page 3

Mr. Quern said.

Both brokers and underwriters are competing almost "head to head" for a large part of the market, which is a "very healthy capitalistic way of doing things," contends William H. Bolinder, president and CEO of Zurich-American Insurance Group in Schaumburg, Ill.

However, a risk manager with truly global exposures needs both a global insurer and global broker in a "three-part relationship," Mr. Bolinder contends.

Saxon Riley, CEO of London-based Sedgwick Group P.L.C., however, sees the buyer's need for a global broker as "slightly more important" than a global insurer.

At the initial step, buyers want independent advice, which can "only come from a broker," he said.

Strategic alliances between brokers and insurance companies are going to be needed in the future in order "to provide the necessary capacity to service global markets," said William E. Buckley, chairman and CEO of Royal Insurance Group in Charlotte, N.C., during an earlier panel.

'The epidemic of quality is sweeping the world. If we don't catch it, we won't survive,' says Mr. Wallace.

These alliances are not apparent in the U.S. domestic market right now because the inability to assess the liabilities of companies stands in the way of consolidation, according to Mr. Buckley.

While many insurers and brokers are expanding their globalization efforts, customer focus and service is the "most important single thing facing us" in the marketplace, contends Donald R. Frahm, chairman and CEO of ITT/Hartford Group Inc. in Hartford, Conn.

"Cycles come and go," he noted. Every business is operating in a very competitive market, therefore each must have a competitive advantage—or added value—that customers respond to if they are going to be successful, he said.

At ITT/Hartford, for example, customer service has displaced profits as the insurer's No. 1 objective, Mr. Frahm said.

"The epidemic of quality is sweeping the world. If we don't catch it, we won't survive," contends J. Bransford Wallace, chairman of Willis Corroon Corp. in Nashville, Tenn.

In a global environment, customers expect high quality service, knowledge of their culture and technological capabilities despite their geographic location, Mr. Wallace said. The creation of a quality management philosophy must "emanate from the top and permeate throughout the entire organization."

And while insurers and brokers increase their focus on customer satisfaction, effectively measuring satisfaction is more difficult.

Most insurers and brokers have a "full range of feedback" including surveys and complaint ledgers, said David A. Kocher, group executive for Aetna Life & Casualty Co. in Hartford, Conn.

However, surveys "don't do the greatest job" because they are often designed "to tell what (the surveyor) wants to hear," Mr. Wallace warned.

The most lasting indicator is the ability to persist and be profitable in a market segment, Mr. Kocher contends.

And while there are many incentives to go abroad, "globalization doesn't come cheap," said Wolfgang Schlink, chairman, president and CEO of Allianz Insurance Co. in Los Angeles. Brokers and insurers need to make sure, "stock holders are behind (them)."

Edward F. Pugh, senior vp and director for Willis Corroon Corp. in Washington and Kathryn J. McIntrye, vp, publisher and editorial director for *Business Insurance* in Chicago, moderated the panels. BI

NAIB progressing on international front after making global concerns a priority

SEA ISLAND, Ga.—International issues dominated the 1992-1993 agenda of the National Assn. of Insurance Brokers, the association's outgoing chairman says.

"Our long-range planning conference gave us a forum to put aside our competitive instincts and share a vision of what our industry could be like in the next decade," said Alan G. Page, director, senior vp and chief information officer of Johnson & Higgins.

Visions for the future included an increase in globalization and an emergence of new free-market economies, he told NAIB members at the 59th annual conference earlier this month in Sea Island, Ga.

In the past year, the NAIB accomplished many tasks on the international front, according to Mr. Page.

For example, the NAIB "took an active role with the federal government in support of (the General Agreement on Tariffs and Trade)," he said. Financial services are in "imminent danger" of being sidelined by trade negotiators notwithstanding their status as a "jewel in our export crown."

The NAIB also joined a broad coalition of companies in favor of the North American Free Trade Agreement, he said. "NAFTA will permit NAIB members to expand their franchises in Mexico and better serve our clients."

The NAIB also took on the Export-Import Bank, which proposed de-privatizing its short-term export insurance program. "Ultimately they prevailed, but they had the privilege of getting to know us before they acted," Mr. Page observed.

At the beginning of the year, two members of the NAIB briefed the media, the office of the U.S. Trade Representative, the departments of Commerce, Justice and State, and the U.S. International Trade Commission on the opportunities U.S. brokers seek in Japan, Mr. Page said.

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The NAIB's proposals for deregulating medium-size and large commercial insurance transactions "was clearly heard in Tokyo," he said.

In addition to international accomplishments, the NAIB, among other things: testified in support of House Energy and Commerce Committee Chairman John D. Dingell's Federal Insurance Solvency Act of 1993 (*BI*, March 15); organized a new NAIB committee on Superfund to develop recommendations for its reauthorization; and took an active role in reducing costs associated with multistate licensing.

Philip F. Petronis, executive vp of New York-based Marsh & McLennan Risk Capital Corp., a subsidiary of Marsh & McLennan Cos. Inc., is the incoming 1993-1994 chairman of the NAIB.

—By Sally Roberts

Lloyd's chairman seeks broker support

SEA ISLAND, Ga.—In addressing what he calls his "most important customers," David Rowland, chairman of Lloyd's of London, is urging the leading U.S. brokers to continue to support financially strapped Lloyd's.

"You are the most important audience that I could possibly speak to," Mr. Rowland told brokers attending the annual conference of the National Assn. of Insurance Brokers earlier this month in Sea Island, Ga.

The "top half-dozen" brokers are "absolutely crucial customers" to Lloyd's, said Mr. Rowland, the former chairman of Sedgwick Group P.L.C. For example, the six largest public brokers worldwide produce 40% of Lloyd's premium volume, the 10 largest produce 51% and the 20 largest produce 70%, he said.

The NAIB's members include the largest U.S. brokers.

But when the media reports on the troubles at Lloyd's, "please read through that and see what is actually happening in the market and the revolution we're bringing about," he urged.

To back up his remarks, Mr. Rowland jokingly joined waiters in serving hors d'oeuvres to his "most important customers" during a cocktail party.

The market is strongly behind Lloyd's restructuring and it has huge potential and opportunity "to offer you the service and strength you have come to demand from Lloyd's. And I hope with your help we can get there," he said.

Lloyd's capacity currently stands at 8.8 billion pounds ($13.33 billion), down from just more than 11 billion pounds ($20.57 billion) in 1992. "This is not as dramatically down as you might expect from reading the media," he said. In addition, the total London market is about twice the size of Lloyd's.

'We desperately want and need to get on with building a new Lloyd's,' says David Rowland.

Although Lloyd's capacity has been declining, "it is still a very significant part of the market," Mr. Rowland pointed out. Nevertheless, Lloyd's is changing "the whole atmosphere in which we operate."

At the end of April, Lloyd's revealed its first-ever business plan, which calls for dramatic restructuring to cap members' past liabilities, deep cost cuts and limited-liability corporate membership starting in 1994 (*BI*, May 3).

"We desperately want and need to get on with building a new Lloyd's. There is no reason at all why we can't turn Lloyd's to the low-cost, efficient market that it was before. . . .None at all," Mr. Rowland said.

—By Sally Roberts

Most employers like flex plans for cost control, survey shows

Offering a flexible benefit program will not directly reduce an employer's benefit plan costs, but it can be an effective tool to help control them.

In fact, controlling future benefit costs remains the primary reason employers adopt flexible benefits, according to 39% of employers surveyed by The Wyatt Co.

And, on average, employers with flex plans estimate saving 8% in annual benefit costs compared with pre-flex benefit costs, the survey found.

Flex plans have grown in popularity over the past decade. Large employers—those with 5,000 or more workers—were the first to embrace the plans, but new growth is coming from smaller firms.

"Small companies initially shied away from flex because the plans were relatively complex and costly to administer," said Thomas Grass, a consultant in Wyatt's San Diego office. "But big corporations have paved the way for easier use," he said, noting that interactive software developed for large companies to administer the plans is now available to smaller firms.

All told, 53% of employers either currently have a flex program or intend to begin one within five years, Wyatt found. An additional 6% of employers intend to implement flex but have not decided when.

The length of time a flex program has been in place has a great bearing on employers' perception of its cost-effectiveness, the survey found. For example, 74% of employers that put in a flex plan before 1990 expressed unqualified support for their decision, compared with about one-third of employers that began plans after 1990.

Most of the employers who adopted flex plans after 1990 indicated it was too early to gauge the plan's effectiveness, but even those companies reported an average savings of 6.3%, Wyatt reported.

The majority of employers—nearly 60%—that cited some type of cost control as the reason behind implementing flex say the program is definitely worth the cost of implementation and operation.

In addition to cost, 36% of employers report adopting flex plans as a way to offer employees choice, and 9% do so to attract and retain employees, the survey found.

For a free copy of the survey, contact Rachelle Green at The Wyatt Co. at 202-508-4810.

—By Christine Woolsey

California law to check non-profit loophole

By LOJISE KERTESZ

SACRAMENTO, Calif.—Blue Cross of California is under fire from several groups that contend it has exploited a loophole in California law that allowed it to reap hundreds of millions of dollars in profits that rightfully belong to the public.

Legislation now in California's assembly would retroactively close that loophole in the state law governing the conversion of non-profit entities to for-profit status. It would also require the health insurer to contribute an unspecified amount of its assets to charitable purposes.

The legislation is ardently supported by the Sacramento-based California Medical Assn. and Consumers Union in San Francisco.

Woodland Hills-based Blue Cross of California, though, contends the conversion law does not apply in its case and stresses that it is still a non-profit entity working for the public good.

The dispute arises from the transfer in January of most of BCC's managed care product lines and companies to a newly created for-profit corporation, WellPoint Health Networks Inc. BCC holds about 80% of WellPoint's stock, while 19.5% was sold in an initial public offering that netted BCC $517 million.

BCC calls the move a "restructuring," because it remains a non-profit corporation.

But the CMA and Consumers Union say that by describing its move as a "restructuring" rather than a "conversion," BCC evaded California law that requires a non-profit organization to donate its fair value to charity when it converts to a for-profit entity. The law is designed to return to the public some of the benefits gained from the tax-free status enjoyed by non-profit firms.

The CMA and Consumers Union support legislation, A.B. 1784, that would amend the conversion law to require a non-profit organization that places a substantial amount of its assets into a for-profit subsidiary to preserve the charitable assets of the organization and to periodically report on how those assets are being used for the public benefit.

The bill, authored by Assemblyman Phil Isenberg, D-Sacramento, would also require that the organization increase the amount of assets dedicated to charitable purposes as its for-profit unit gains in profitability.

And, the measure would allow anyone to sue members of a non-profit organization's board of directors for violations of its provisions. The bill, which would retroactively apply to BCC's formation of WellPoint, has passed the Assembly but is not yet scheduled for a hearing in the Senate.

The CMA and Consumers Union claim the legislation is necessary because WellPoint's need for profits and dividends to satisfy its stockholders will supplant BCC's interest in operating for the public benefit.

As evidence, they point to BCC's move late last month to increase premiums in its preferred provider network while reducing payments to some specialty doctors, which they contend was done primarily to boost profits (*BI*, May 31).

Several consultants contacted by *Business Insurance* would not comment on BCC's restructuring, citing their relationships with the insurer.

But Peter Kautz, a consultant with Alexander & Alexander Consulting Group in San Francisco, who places coverages with BCC, observed: "Usually a company becomes stronger when it goes public."

"BCC almost died of its own weight four years ago," he pointed out, explaining that increased efficiency brought about by BCC Chairman and Chief Executive Officer Leonard D. Schaeffer turned the company around.

"I think the CMA is posturing" when it charges that employers should be wary of BCC's move to create WellPoint, Mr. Kautz said.

"When the restructuring was in the papers about six months ago, employers asked about it. Their only concern was whether their premiums would go up, and we told them they shouldn't be concerned," Mr. Kautz said.

Other publicly traded health insurance companies, "like Aetna, do very well" in the California marketplace, Mr. Kautz added.

Premium increases for Mr. Kautz's clients are based on claims experience, he said. Of the average increase announced by BCC, "as far as I'm concerned, that's a bargain," he said.

"We intended (the restructuring) to be invisible to our customers, and I think it has been pretty invisible," said John Patrick Garner, senior vp of BCC.

"Even under the worst scenario, that this legislation passes," customers will not be adversely affected, Mr. Garner contends.

The Blue Cross & Blue Shield Assn. in Chicago "continually scrutinizes plans" to ensure they are meeting rules and regulations of the franchise, said a spokeswoman. She said she was not aware of any objection the association had to BCC's restructuring.

Eleanore Hill, staff director and chief counsel of the U.S. Senate's permanent subcommittee on investigations, which has scrutinized several Blues plans, said the subcommittee has no current plans to look into BCC.

"One of the issues the subcommittee is looking at is the (for-profit) subsidiary issue" and its "appropriateness" for Blues plans, said Ms. Hill, pointing out that Blues plans investigated by the subcommittee "had serious losses in their for-profit subsidiaries."

However, she added, "I'm sure it's a case-by-case thing, because some Blue Cross plans have been successful" with for-profit operations.

The for-profit subsidiaries that got some Blues plans in trouble "are not managed care and are not insurance" but are "diversification outside their core business," added BCC's Mr. Garner.

"The whole rationale behind a for-profit company is to do well for its shareholders, and BCC is WellPoint's biggest shareholder," he stressed.

BCC defends its creation of WellPoint. "There's tremendous uncertainty as to what's going to happen to health care in general and to the people who supply insurance and manage health care companies," Mr. Garner said.

The restructuring "created over $500 million for Blue Cross to do a number of things. . .to be able to react to whatever happens."

Since BCC remains "a public benefit corporation, that infusion of capital is going to continue" to work for the public benefit, Mr. Garner asserted.

But the CMA disagrees, and points to the actions of other California non-profit health care companies that converted to for-profit entities.

For example, Woodland Hills-based Health Net created The Wellness Foundation in 1992. Health Net formed the independent foundation with a grant of $300 million plus equity in the for-profit company, said Joe Criscione, Health Net senior vp-government relations.

And Fountain Valley-based FHP Health Care established the FHP Foundation in 1985, at an estimated total cost of $38.5 million, according to information provided by the CMA.

The foundations are health care-related charitable organizations that provide grants for free or subsidized health care programs, such as immunizations and education, among other things.

Extrapolating the $517 million that was gained from the sale of about one-fifth of WellPoint, the CMA projects that BCC is worth about $2.6 billion. But the CMA and its backers in the Legislature are not insisting that BCC hand over the entire amount.

BCC should just "make us an offer," said Gene Erbin, counsel to the Assembly Judiciary Committee, which is chaired by Assemblyman Isenberg.

"We just think they owe the public a substantial sum of money," he added. "We don't think that their mere existence alone is charitable."

BCC should acknowledge its "legal and moral obligation" and enter into a "reasonable" discussion about how much money it owes the public. But instead, "they've just dug in their heels," according to Mr. Erbin. "They're stubborn."

"We don't want to strip them of their assets. If they write a check tomorrow, we would go away," he said.

Other non-profit HMOs that converted to for-profit status and set up charitable foundations have not come out in support of the legislation, Mr. Erbin said. "We haven't actively solicited their support. It was not our intent to ignite internecine warfare," he said.

"We've elected not to take a position on this issue and remain neutral to it," said Health Net's Mr. Criscione.

He noted the conversion process for Health Net and FHP was "complex," in part because of differing mechanisms to establish the companies' "fair value." In addition, there is still a lawsuit pending, filed by an HMO that wanted to buy Health Net, that challenges the value placed on the health care company at its conversion, said Mr. Criscione.

BCC is fighting legislative efforts to attach its assets.

"I think the arguments we're making will have some effect" on legislators, Mr. Garner said.

"There is one essential argument here: This restructuring either was or was not a conversion" to a for-profit entity, he said. "It wasn't a conversion legally or conceptually. Blue Cross is still here. The board still has 97% voting control over WellPoint. WellPoint is an asset of Blue Cross. The concept that somehow the public benefit has gone away is not so," he said.

"If it's good public policy for public benefit companies to report on their activity, then let's have a bill that requires that," said Mr. Garner.

Such a bill would define activity for the public's benefit and require a standard reporting form, he said.

"And then let's look at those reports and see how BCC stacks up against its competitors. Let's not rush to judgment. Let's find a way to put everybody on the same ground," he said. BI

ALCOA, Reynolds and unions agree to pact featuring managed health care

By CHRISTINE WOOLSEY

PITTSBURGH—Aluminum Co. of America and Reynolds Metals Co. have reached a tentative agreement with unions that, among other things, eliminates first-dollar health care coverage for nearly 17,000 unionized steel and aluminum workers.

Members of the United Steelworkers of America and the Aluminum, Brick and Glass Workers International Union have tentatively agreed to ratify a new three-year contract that will favor employees and dependents treated by managed health care providers.

Workers treated by network health care providers will not have to pay deductibles or coinsurance and are not subject to out-of-pocket or lifetime maximums.

ALCOA and Reynolds will pay 100% for most medical care, including inpatient and outpatient surgery, home health and hospice care.

Employees must pay $10 for doctor visits, preventive care and some other services.

Employees not treated by network health care providers must pay a $200 deductible for single coverage, $400 for family coverage and 20% of all medical expenses.

Out-of-network health care benefits are subject to a $250,000 lifetime maximum, and preventive health care services are not covered.

The agreement increases workers' pension benefits $2 per month for each year of service. In addition, the agreement guarantees minimum pension payments of $1,070 to $1,250 per month—depending on a worker's job classification—for employees age 55 or older with at least 30 years of service. BI

ASK A RISK MANAGER

Self-insuring work comp expands responsibilities while trimming costs

Q **Like many other large companies, we are seriously considering self-insuring our workers compensation program. What are some issues for us to consider?**

A I am not surprised that you are considering a self-insurance program for workers compensation if you have not already done so. I gather from your question that your company presently pays a substantial workers compensation premium and is large enough to meet the basic premium-level criteria for self-insurance to be practical.

Let me begin by emphasizing that self-insurance definitely has its merits as a cost-saving mechanism, but it imposes very specific responsibilities on those who are approved to participate in this type of coverage program. Self-insurance is exactly what the term implies. You are "standing in the shoes" of an insurance company and must be capable of and committed to professionally handling workers compensation issues on behalf of your employees.

However, before I comment on claims handling matters, I must caution that your organization's financial strength will determine whether state officials allow you to qualify as a self-insurer. Your company will be responsible for funding losses, and its financial statement must demonstrate that resources are available to do so. As part of this fiscal responsibility, additional security in the form of a surety bond is required by state officials.

It is understood that workers compensation costs are directly related to loss experience. In too many instances, we focus primarily on finding the most economical means of funding losses rather than trying to prevent them. Every self-insurer realizes the importance of having a solid, well-executed safety program. You will be queried about your safety program as part of the application process since state workers compensation administrators understand the importance of management's commitment to safety in the workplace.

How are your claims currently managed? Do you use the claims administration services of an insurance company or do you have an "unbundled" program? If the latter is the case, you're a step ahead of the process. In every state where we self-insure, the question of who would handle the adjustment of our claims was an important one posed by the state regulators. We also learned that several states require you to select a third-party claims administrator that has offices in these particular states.

And, if you don't have a claims reporting process in place that provides for immediate notification of employee accidents and illnesses, you had better get busy and implement one! In recent years, state administrators have taken an aggressive approach to assure claims are reported within a tight time frame. It has become routine for late reporters to be fined for their bad habits and even those organizations presently approved as self-insurers are regularly graded on how quickly claims are expedited. Because of our multistate operations, claims reporting issues are extremely important to us and require constant surveillance to make certain we are "up to par" with these standards.

In addition to the claims handling process, the entire scope of proper case management must be considered. You will be expected to offer services such as occupational rehabilitation and subscribe to cost-saving mechanisms such as utilization review. The TPA you select for claims management should be able to offer these services as well as provide access to PPO networks and provider bill-auditing programs. Keep foremost in your mind, if you can't prevent accidents from happening, you should employ every reasonable technique to control the cost of that loss.

If you are fortunate to be approved as a self-insurer, and operate as such in several states, you will eventually realize an increase in your administrative responsibilities. State officials require self-insured employers to complete various paperwork at certain intervals. Now is the appropriate time to evaluate the current demands on your staff and decide if additional headcount will be needed to handle the additional responsibilities.

As you would expect, the reporting of workers compensation loss data to state administrators is a priority item. The process is almost impossible without having a computerized risk management information system. Try juggling figures and loss descriptions on a variety of reporting forms without one. I guarantee it will be a true test of your sanity! The credibility of your loss data is critical since you are accountable for the funding of outstanding claim reserves, and the information also serves as the basis for various self-insurance assessments.

In conclusion, I leave you with this thought. Self-insurance is considered a privilege, not a right. Your organization's desire to move in this direction focuses additional accountability and responsibility on your position. By entering into the arrangement with a clear understanding of your role and that of your service providers, you'll be able to achieve your objective. BI

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefits Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field.

Ms. Werner

Ms. Werner's next column will appear in September.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Heart transplant not covered procedure: Court

Coverage is excluded for heart transplants under a group health insurance policy that did not list it as a covered procedure, according to the Colorado Supreme Court.

Michael J. Wota was insured under a group health plan issued by Blue Cross & Blue Shield of Colorado. The policy paid for medically necessary services and supplies subject to certain limitations and exclusions. Organ transplants were listed under the limitations and exclusions applicable specifically to surgery. The limitations and exclusions clause provided that, if an insured was a recipient of an organ transplant, and was charged for the services furnished by the donor, covered charges were allowed. It also listed only certain transplant procedures that were allowed. Heart transplants were not on the list. In July 1987, Mr. Wota underwent successful heart transplant surgery. Initially, Blue Cross paid expenses related to the surgery. Subsequently, Blue Cross retroactively denied coverage. Mr. Wota sued Blue Cross but lost in the trial court.

Legal Briefs

On appeal, Mr. Wota argued that the exclusion clause that listed those transplant procedures that were covered applied only to donor services. The court disagreed. "The organ transplant limitation and exclusion under the surgery provision in the policy lists those transplant procedures which are covered," the court said. Since heart transplant procedures were not listed, and because the policy provided that only those procedures listed were covered, heart transplant surgery was not covered, according to the court. The court found that the policy was unambiguous. The trial court decision was affirmed.

Wota vs. Blue Cross & Blue Shield, Supreme Court of Colorado, June 29, 1992 (*BI*/04/Ju.-$10).

Group policy coverage limited

A group health insurance policy, unlike an accident policy, does not extend coverage for expenses incurred after the termination of the policy, the Arkansas Court of Appeals ruled.

In November 1984, Paul Foerster's wife began work at a bank and was covered under a group medical plan issued by Arkansas Blue Cross & Blue Shield. Foerster became an insured member of the plan by virtue of his wife's having selected the option of family coverage. In April 1985, Mr. Foerster sustained a work-related injury to his back. Shortly thereafter, his wife quit the bank for employment elsewhere.

The BC/BS policy required premiums to be paid in advance on a monthly basis. The contract would terminate as of the last day of the month for which premiums had been collected. Since Ms. Foerster was no longer employed by the bank, her name was not included in the group billing statement for June 1985, and consequently no premium was remitted.

Mr. Foerster continued to receive treatment for his back culminating in surgery in September 1985. He sought coverage for the treatment he received after the policy was terminated. BC/BS denied coverage. He sued and won in the trial court.

The appellate court concluded that the BC/BS policy insured against the incurrence of medical expenses and that benefits, therefore, ceased when the policy was terminated. The court emphasized that this policy was different from one which insured an accident or illness where the insured risk is the accident or illness itself. Thus, the court said that BC/BS was not responsible for the expenses which arose after the policy was terminated. The trial court decision was reversed.

Arkansas Blue Cross vs. Foerster, Arkansas Court of Appeals, June 3, 1992 (*BI*/01/Ju.-$10). BI

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler, to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

Laws demand new comp strategies

By MEG FLETCHER

SCOTTSDALE, Ariz.—Employers can adopt several strategies to help them cope with the impact of two federal laws on their workers compensation programs, an attorney says.

Otherwise, he warned, the Americans with Disabilities Act and the Employee Retirement Income Security Act can create workers comp headaches.

"Many of the (ADA) claims will come from workers compensation," said Lawrence P. Postol, an attorney with Seyfarth, Shaw, Fairweather & Geraldson in Washington.

"Anybody who has a permanent work restriction is covered by the ADA," he said. In addition, an injured worker may be more inclined to sue than others covered by the ADA because they may already have retained a workers comp lawyer, Mr. Postol said at the annual meeting of the National Council of Self-Insurers last month in Scottsdale, Ariz.

Workers with temporary conditions like a broken leg also may be covered by the ADA if the injury is severe, he said.

Employers that want to return a disabled employee to the job with a minimum of risk should first ask questions about physician-imposed limitations so they fully understand them, he said. For example, a "no bending" limitation could mean "no excessive bending," "no bending with back but can bend with the knees" or "can bend to lift anything under five pounds."

An employer can exclude a disabled worker from a particular job, though making such a determination requires using medical criteria or tests that are job-related and a "business necessity," Mr. Postol said. Some of those criteria may be found in other federal laws or some state laws, such as requiring airplane pilots to have 20/20 vision.

"As a practical matter, this means persons with a medical condition cannot safely perform the essential functions of the job even with reasonable accommodations which are not an undue hardship," he said.

However, there are limits on applying the safety exclusion. There must be "significant risk of substantial harm"—which probably means "high probability"—based on evaluation of the worker's current condition using the best available objective evidence, Mr. Postol said.

In addition, the exclusion applies only if the risk cannot be reduced to an acceptable level by making reasonable accommodations, he added.

Accommodations for a worker with back injuries could include: purchasing a lift or crane; putting work on a workbench; having someone else perform lifting tasks; reassigning the lifting if it is not an essential job function; or providing the worker with back support.

When workers are injured on the job, "smart" employers will bring them back to a light-duty job so they don't develop the "workers comp syndrome" of enjoying staying home and collecting benefits.

Light-duty jobs typically consist of duties like washing goggles or sorting nuts and bolts.

However, some workers may want to linger in light duty too long.

One employer solved that problem by putting the light-duty jobs in the "dirtiest, filthiest, hottest part of the factory," he said. "It's light duty, but it's not enjoyable duty, so people tend to recover from their injuries very quickly."

But even a smart employer may face problems if a disabled job applicant applies for a vacant light-duty job, which the ADA allows, Mr. Postol said.

The solution is to make light-duty jobs temporary, lasting six months or one year at most, he advised.

In addition, employers should not overpay for the work done, though an injured employee's light-duty earnings must be supplemented by workers compensation indemnity benefits.

Another problem some employers face is union resistance to setting aside light-duty work for injured workers rather than reserving it for senior union members. Federal authorities are supposed to provide additional guidance on this controversial issue, Mr. Postol said.

Employers can best cope with the ADA by designating a single, in-house employee to act as an Equal Employment Opportunity Commission liaison officer to daily deal with ADA compliance issues, Mr. Postol said. People who don't deal with ADA compliance daily will make mistakes, he said.

Mr. Postol also offered employers some ERISA-related advice on workers comp matters.

He cited a 1992 U.S. Supreme Court ruling that struck down a District of Columbia law requiring employers to extend group health care coverage to employees receiving workers comp benefits (*BI*, Dec. 21, 1992).

In an 8-1 ruling, the justices held that ERISA pre-empted the district's 1990 law. That law required employers that provide health insurance for active employees to provide equivalent coverage for workers receiving workers comp benefits, even if they are no longer able to work (*BI*, Oct. 12, 1992).

The U.S. Supreme Court ruling effectively "voids" similar laws in Connecticut, Oregon and Rhode Island, Mr. Postol said. In addition, it "probably voids laws which include health benefit value in the average weekly wage" that injured workers receive in Alabama, Colorado, Florida, Kansas and Maine.

A negative side effect of the Supreme Court's decision is it also voids workers compensation credits for pension benefits, he said. However, employers can find "an easy solution" to that problem by modifying their pension plans so they specifically state that credits are given for workers comp benefits, Mr. Postol added.

Mr. Postol also said employers should be aware of the recent STAFCOR case in California, in which an employee leasing company that provided workers comp benefits through a self-insured plan claimed that ERISA pre-emption meant it was exempt from the state's workers compensation regulations.

A U.S. District Court rejected that argument (*BI*, March 22). BI

For the Record

1st Circuit upholds cleanup decision

BOSTON—A federal appeals court late last month upheld a 1992 trial court's ruling that New England Electric System & Subsidiaries Inc. is wholly responsible for cleaning up a polluted 41-acre site in Lynn, Mass., despite the fact the utility sold the site 20 years ago to another utility.

The 1st U.S. Circuit Court of Appeals ruled that Boston Gas Co. did not assume open-ended liability on the site when it purchased the land from NEES in 1973.

The pollution is determined to have occurred prior to 1973, according to court papers.

A NEES spokesman said it's doubtful that the U.S. Supreme Court will be asked to review the case.

NEES does not have insurance to cover the cleanup, the cost of which cannot yet be estimated, the spokesman said.

Defense contractor shielded from liability

CINCINNATI—The widow of a U.S. Army officer killed in a helicopter crash will ask a full federal appeals court to reverse a panel's ruling that exempts the aircraft's manufacturer from liability even though it did not comply with some design specifications.

A panel of the 6th U.S. Circuit Court of Appeals last month ruled 2-to-1 to affirm a lower-court summary judgment that McDonnell Douglas Helicopter Co. is shielded from liability for the crash under the government contractor defense.

The officer was killed when his helicopter crashed in May 1988 after the aircraft's main rotor blades severed the tailboom during an emergency maneuver.

The clearance between the main rotor blades and the tailboom did not comply with military design specifications for helicopters in general.

But, the helicopter's design conformed to the final specifications the government approved for that particular helicopter. Therefore, the general design specifications did not govern the helicopter's final design, the courts ruled.

The plaintiff argued that McDonnell Douglas did not have official permission to deviate from the general specifications.

The ruling is not a radical twist on the government contractor defense, according to defense attorney Fred S. Souk, a partner with Crowell & Moring in Washington. But, it highlights the difficulties that litigants will face in seeking summary judgments as more of these cases head to court as the military increasingly procures complicated machinery, he said.

Small group reforms enacted in Wyoming

CHEYENNE, Wyo.—Insurers in Wyoming's small-group health care coverage market now are required to offer state-approved basic and standard health plans on a guaranteed-issue basis.

The plans were developed by a committee that Insurance Commissioner John P. McBride appointed under the Small Employer Health Insurance Availability Act, enacted in 1992 and amended this year.

The law, which became effective June 1, applies to groups with two to 25 employees.

Both plans offer comprehensive medical and hospitalization benefits, including maternity and well-child care, but the standard plan offers richer benefits.

Insurers can continue to market plans presently being sold. The companies also are allowed to consider the health histories of applicants for those plans.

If an insurer denies its regular coverage for a group, the insurer is required to offer that group the basic and standard plans.

Repercussions felt from pollution ruling

SAN DIEGO—The impact of the *Shell Oil Co. vs. Winterthur Swiss Insurance Co.* decision was felt in another case in California even before the state's high court denied petitions for review and rejected a request that the anti-policyholder decision be depublished.

Adopting the reasoning of the California Court of Appeal in *Shell vs. Winterthur* (*BI*, Jan. 25), a San Diego Superior Court applied a temporal meaning to "sudden" and ruled that discharges of pollutants from underground storage tanks caused by corrosion were not covered under comprehensive general liability policies.

The San Diego Superior Court's April 12 decision in *Service Control Corp. vs. Liberty Mutual Insurance Co. et. al.* came nearly a month before the California Supreme Court on May 13 rejected petitions seeking review of the Shell decision, indicating that the judge in the case already viewed the ruling as a precedent.

The court had earlier denied the insurers' motions for summary judgment, finding that the pollution exclusions contained in the CGL policies were ambiguous.

California work comp legal expenses rise

SAN FRANCISCO—Litigation costs in California's workers compensation system reached a record $2.2 billion last year, according to a biannual California Workers' Compensation Institute study.

Litigation costs represented 21% of the estimated $10.6 billion that employers paid last year in work comp costs. 1992 litigation expenses were 48% higher than the previous record of $1.5 billion in 1990.

Litigation costs, which include attorneys' fees, forensic medical reports, and related employer and injured-worker expenses, averaged $8,649 per case for disputed claims resolved, up 23% from $7,030 in 1990, the CWCI said.

A recent law is intended to reduce the costs of medical-legal reports, which cost $1,196 per case. An average of 3.8 reports were used in every disputed claim resolved last year.

Attorneys' fees totaled $864 million last year, up from $668 million in 1990.

The average value of awards and settlements in 1992 was $12,264. After deducting the applicant attorney's fee—which averaged $1,396—net benefits to the injured worker were $10,868. That means it cost $8,649 in litigation expenses to deliver $10,868—or 80 cents to give $1 in benefits, the CWCI said.

Information in brief

Dwight K. Bartlett III, onetime head of Mutual of America Life Insurance Co., was named **Maryland insurance commissioner**. . . . As part of a settlement with the New Jersey Insurance Department, Aetna Casualty & Surety will pay $1.2 million to settle a debt with the **New Jersey Joint Underwriting Assn.**, a defunct pool for poor auto risks. In addition, Aetna will pay $5.9 million for its share of 1992 underwriting losses for the JUA's successor, the Market Transition Facility. . . .A New Jersey Assembly panel is proposing to amend the state's **Environmental Cleanup and Responsibility Act** to explicitly state that businesses can use environmental insurance to fund pollution cleanup. The panel aims to encourage insurers to write the coverage and to cut pollution cleanup costs for companies. . . .**Western Lloyds Insurance Co.** of Beaumont, Texas, has been declared insolvent. The Insurance Department says the company's liabilities exceed its assets by $9.2 million. BI

Rep. Cooper

Continued from page 2

cratic Forum, a group of about 60 House Democrats, many of whom backed a managed competition bill Rep. Cooper proposed last year. This year, Rep. Cooper deliberately has held off introducing his bill in the hope that the Clinton administration would come up with an acceptable reform bill that he and other CDF members could back.

Because of its size, the possible loss of CDF support would be a critical blow to the administration's effort to gain a solid block of Democratic support for its health care reform proposal.

But the administration's decision to delay its health care reform may work in favor of managed competition advocates, Rep. Cooper said.

Had President Clinton unveiled a reform bill in May, as he originally promised, the proposal likely would have had little in common with managed competition, Rep. Cooper said. At that time, "The single-payer activists had the upper hand."

But delaying the proposal gives employers a chance to get their views across that a strongly government-regulated health care system will not work, he said.

In fact, the administration's recent embarrassment when it was unable to get passage of an economic stimulus bill and its need to obtain business support for its pending tax bill may make the administration more accommodating of employer views as it continues to draft a health care reform package, Rep. Cooper said.

The role of health care purchasing alliances in a reformed health care system underscores the differences between backers of managed competition, like Rep. Cooper, and some of the president's health care advisers.

Rep. Cooper said purchasing alliances should be a mechanism to band small employers and individuals together and to give them greater clout in the market. While government could facilitate the formation of purchasing alliances, it should not run them. At the same time, big employers that already command buying clout should not be required to join the alliances.

By contrast, some Clinton administration advisers want to give states the ability to limit the number of purchasing alliances as well as run them, while effectively forcing all employers into the alliances. Employer groups complain that this would amount to a single-payer health care system.

Rep. Cooper also noted that some administration advisers favor government price controls on health care services. Managed competition backers, said Rep. Cooper, are dead set against price controls, believing controls never have worked. BI

INTERNATIONAL

UNI Storebrand, Hafnia sell Skandia shares

By MARIA KIELMAS

OSLO, Norway—Norway's UNI Storebrand and Denmark's Hafnia Holding have sold a combined 39.8% stake in Sweden's Skandia Group, paving the way for UNI Storebrand's proposed reorganization despite opposition from the Norwegian insurer's shareholders.

The stake of more than 30.5 million Skandia shares, which was sold last week for 3.2 billion Swedish kronor ($441.3 million), came after a previously unknown agreement between UNI Storebrand and Hafnia was revealed.

The agreement, signed by former UNI Storebrand Chief Executive Jan Erik Langangen and former Hafnia CEO Per Villem Hansen, stipulated that neither company could bail out of their attempted takeover of Skandia without permission from the other.

UNI Storebrand and Hafnia acquired the Skandia stake in 1991 and tried last year to buy the Swedish insurance group. The takeover attempt failed because of Skandia's restrictive shareholder voting rights, and UNI Storebrand and Hafnia later entered bankruptcy (*BI*, Aug. 31, 1992; Dec. 2, 1991).

UNI Storebrand and Hafnia had jointly held a 43% Skandia stake, most of which was sold last week. UNI Storebrand Life will retain a 3.26% stake in Skandia.

The sale of the Skandia stake was managed by London-based stockbroker Barclay de Zoete Wedd and Carnegie International in Stockholm. Shares were placed among international institutional investors, but there were no strategic buyers, a stock market source said.

According to London and Oslo stock market sources, BZW and Carnegie International were eager to complete the placement of UNI Storebrand's 28% of Skandia shares by June 3. But the transaction was delayed by opposition from Hafnia Holding because of the prior agreement between the two companies. By June 1, both insurers and stock market analysts in Norway were predicting a collapse of the UNI Storebrand financing plan.

Skandia Chief Executive Bjorn Wolrath said last week that the sale was "good news for us. . . .The fact that international investors have chosen to make an extensive investment in a Scandinavian insurance company must also be interpreted as a sign that investors have once again begun to view the Scandinavian market favorably."

But, UNI Storebrand's reorganization plan—which has been opposed by the company's small shareholders—called for the transfer of the insurer's 24.7% Skandia stake to a new subsidiary called Skandia Holding and the eventual sale of those shares (*BI*, April 26).

The Norwegian Ministry of Finance recently approved the latest 4.5 billion Norwegian krone refinancing package ($654.3 million). The package also includes writing down the value of UNI Storebrand shares to 5 Norwegian kroner from 20 Norwegian kroner (to 72 cents from $2.91), a 2.8 billion krone ($407.1 million) share issue and a 1.8 billion krone ($261.7 million) bond issue.

Meanwhile, UNI Storebrand's small shareholders are continuing their opposition to the refinancing program. Martin Imbach, chairman of Zurich-based Insurance System, a financial services company whose subsidiary, Capital Bank, is the largest foreign shareholder in UNI Storebrand, said he thinks this latest package will fall apart.

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Photo by AP/Wide World

The four-star Holbeck Hall Hotel began to fall into the sea June 4.

Hotel's slide questions desirability of insuring English coastal risks

By ADRIAN LADBURY

SCARBOROUGH, England—Many U.K. insurers will be traveling to the Northeast coast of England over the next few weeks to visit the Holbeck Hall Hotel in the seaside resort of Scarborough and the surrounding area—but they won't be going for a summer holiday.

The 100-year-old hotel slipped from its cliff-top perch into the sea on June 4 and 5, and is being described as a "constructive total loss" by underwriters.

Insurers are concerned that many other properties along England's Northeastern coast also are at risk. While erosion caused by the sea is not covered under U.K. property insurance policies, losses due to subsidence are covered.

The hotel has 3 million pounds ($4.6 million) in property coverage and 1 million pounds ($1.5 million) in business interruption coverage with a 24-month indemnity period.

CIGNA Insurance Co. of Europe S.A. N.V. confirmed that it led the property policy with 60% of the risk. If the property loss is paid out in full, it will cost CIGNA 1.8 million pounds ($2.7 million), according to Colin Wooler, CIGNA's marketing director. CIGNA does not reinsure the coverage.

"We are not going to go into a tailspin over one hotel slipping into the sea, but it is fair to say that the business of insurance is to continuously review the desirability of the risks that are covered. So we will review the risks in this area," said Mr. Wooler.

Two CIGNA surveyors began assessing the hotel site last Monday and were expected to submit a full report on the cause of the loss by Friday.

CIGNA and other coastal property insurers were eagerly awaiting

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Lloyd's may be 'unrealistic' about investment capital

LONDON—There will be a lot less corporate capital available to invest in Lloyd's of London by next January than the market contemplates, warns a market analyst.

Lloyd's Chief Executive Peter Middleton has said he expects the market's capacity to hover somewhere around 10 billion pounds ($15.22 billion) come the beginning of next year. This would mean an influx of 1.3 billion pounds ($1.98 billion) in new capacity, presumably from corporate capital.

But "the numbers talked about are unrealistic," said Oliver Laughton-Scott, director of consulting firm De Lisle Jessup Scott in London. He said he would be "amazed" if the market attracted billions of pounds in corporate capital by January, and thought the "talk of 200 million pounds" ($304.4 million) was more realistic.

In time, though, Mr. Laughton-Scott is "optimistic" about the introduction of corporate capital into Lloyd's. The market has "a superior capital structure" that is unmatched in the world, he said. Lloyd's also is uniquely regulated throughout the world, which will attract corporate investors.

The proposals in Lloyd's business plan may spell the end of many members agencies that currently exist, however, concluded Mr. Laughton-Scott's recent report, "Lloyd's Advisors: Meeting the Needs of the Investor and the Market."

The report concludes that there could be as few as six members agents in the future because Lloyd's plans to dictate a minimum capacity size for each agent. Already, the top five members agents represent 34% of the market's capacity, including Sturge Members' Agency, which controls 10.5% of the market's capacity, and Sedgwick Underwriting Agency Ltd., which controls 8.5%.

Although Mr. Laughton-Scott's report speculates about what form a "corporate names adviser" will take, it points out that Lloyd's "rule book" for these firms won't be published until July.

The report also warns Lloyd's that some suggestions in the business plan aren't doable.

For example, the report says that "proposals for auctioning capacity may prove impossible to implement." Lloyd's plans to invite bids for capacity from current and prospective providers of incorporated capital after it announces its annual target capacity for the next year's account in June. The bids would then be ranked in descending order starting with the highest bid, and a price would be struck.

But, Mr. Laughton-Scott states that "it is unclear whether there will be enough surplus capacity to allow the auction process to proceed."

Corporate investors will want to commit capital to selected syndicates and not the market as a whole. A bidding system would also prove unacceptable to potential investors, he added.

It "seems inevitable, at least initially, (that) there will be a mismatch between corporate aspirations and the reality offered by Lloyd's, which may have an adverse effect on the level of corporate capital made available in the early stages," the report adds.

—By Stacy Shapiro

Fondiaria breakup possible: Analyst

FLORENCE, Italy—Italy's third-largest insurer, Gruppo Fondiaria, could be broken up and sold off piecemeal in an attempt to reduce its corporate debt, an analyst said.

Gruppo Fondiaria reported a 580 billion lire ($392.4 million) consolidated loss for 1992, on top of existing corporate debt of 2 trillion lire ($1.35 billion).

The insurance group is a wholly owned subsidiary of SEPAD S.A., a holding company that is held in equal proportions by the Feruzzi family and the heirs of the late Italian entrepreneur, Camillo de Benedetti. Mr. de Benedetti, a former director of Italy's largest insurer, Assicurazioni Generali S.p.A., died three months ago. The Feruzzi family controls one of Italy's largest industrial and financial groups. Its main holdings are Gruppo Fondiaria and the chemicals and food giant, Montedison S.p.A.

According to Tony Morrongiello, Italian equities specialist at London stockbroker Carnegie International, both Fondiaria and the Feruzzi family need to liquidate their vast debts.

"When you think about it, there is no synergy between insurance and the agrichemicals business," said Mr. Morrongiello. "Nor is there any logic for the heirs of Camillo de Benedetti to be involved, either. It's possible that Fondiaria could be completely dismembered."

Fondiaria announced in late May that it will concentrate its financial and management resources on those insurance activities under its direct control. The previous week it had announced that it would sell its 21% holding in German insurer Aachener & Munchener Beteiligungs-A.G., as well as its one-third share of European Partners for Insurance Co-operation, a joint venture with AMB and U.K. insurer Royal Insurance P.L.C. The sale of its interest in AMB could bring in about 1 trillion lire ($680.4 million), leaving the company to find another 1 trillion lire to liquidate its debt, Mr. Morrongiello said.

In its latest announcement, Gruppo Fondiaria said it would dispose of "significant, but minority"

Continued on next page

GLOBAL BRIEFS

Corporations now eligible to become members of AIRMIC

LONDON—More than 75% of the members of the Assn. of Insurance & Risk Managers in Industry & Commerce voted to immediately allow corporate membership for the first time in the organization's history.

Corporations will be allowed to include three to five qualified employees in their AIRMIC membership. Individuals who spend more than 60% of their professional budgets on insurance or risk management affairs will still be entitled to membership.

AIRMIC first touted the idea of corporate membership at its annual conference in Warwick, England, earlier this year.

INTERNATIONAL

GLOBAL BRIEFS

Continued from previous page
holdings in international insurance companies.

Gruppo Fondiaria consists of four operating units: La Fondiaria Assicurazioni S.p.A., a property/casualty insurer; multiline insurer La Previdente Assicurazioni S.p.A.; Milano Assicurazioni S.p.A, which writes mostly auto insurance but also writes life products; and multiline insurer Latina Assicurazioni S.p.A. The aggregate gross premium written by those companies in 1992 was 6.1 trillion lire ($4.13 billion), an increase of 20% over 1991 premium volume.

The group's total loss for 1992 was 495 billion lire ($334.9 million), of which 68.7 billion ($46.5 million) was carried over from the previous financial year. Gruppo Fondiaria said the losses were largely from reinsurance written by its units and the fall in value of various assets.

Mr. Morrongiello believes the Milano subsidiary may be one of the first companies to be sold. Gruppo Fondiaria has been gradually decreasing its stake in Milano. Although it has not released precise current figures, its holding in the auto insurer is thought by stock market analysts to be in the 30% to 40% range. The other majority shareholder in Milano is the bank, Instituto San Paolo di Torino, which holds 22%. Mr. Morrongiello believes the bank could take a controlling share and ultimately turn Milano into an in-house insurer.

—By Maria Kielmas

Skandia profits up

STOCKHOLM, Sweden—The Skandia Group says it is on the road to recovery, and analysts are upbeat about the insurer's prospects for expanding its domestic market share.

The insurer posted a first-quarter profit of 11.7 billion kronor ($1.55 billion), up 21.9% from the 9.6 billion kronor profit ($1.61 billion) for the same period in 1992. The company attributed the improvement mainly to an increase in profits from life insurance business at its international units.

Skandia Group's net asset value as of March 31 is estimated at 12.6 billion kronor ($1.67 billion), compared with 11.3 billion kronor ($1.6 billion) at year-end 1992.

Skandia said the increase in asset value is improving the insurer's solvency margin, and the solvency trend is strengthened by Skandia's cutback on non-life reinsurance. In 1993, the solvency margin is expected to rise to 65%. It was 54% at the end of 1992.

The company also announced that it will resume calling itself Skandia Insurance Co. Ltd. rather than Skandia Group, the name it acquired in the 1980s.

According to a study by Mike Wheelhouse, insurance analyst at London-based stockbroker Nomura International, Skandia could have a 20% market share in Scandinavia by the middle of the decade.

He said Skandia will be the market leader within the Scandinavian insurance sector, which—combining Sweden, Norway and Denmark—is the fifth-largest in Europe, including the United Kingdom.

—By Maria Kielmas

Fiji windstorm program

BRISBANE, Australia—A mandatory commercial building inspection program introduced after severe windstorms hit in 1985 spared Fiji Island underwriters a repeat of heavy losses when a similar disaster struck earlier this year.

Local insurers and their clients that had implemented the building standards sustained less than 20% of the $30 million in insured losses caused by Cyclone Kina in January.

Non-resident insurers, which had not insisted on windstorm protection nor encouraged risk management, bore the brunt of the loss, according to John Cloney, CEO of Sydney-based QBE Insurance Group Ltd., which has operated a Fiji office since 1918.

In 1985, two violent cyclones devastated Fiji. "No real building standards existed to assist in minimizing wind-related damage," he said. Industry losses of $52 million were about three times annual premium for all classes. As a result, some insurers left the market.

The 1985 storms were "the straw that broke the camel's back" for insurers operating in Fiji that had been hit by Cyclone Oscar on March 1, 1983, said Brian Cotterill, QBE's assistant general manager of international operations.

About half the insurers in the Fiji market pulled out, leaving three insurers to choose whether to triple premiums and endeavor to recoup losses, or delete wind-related coverage from policies. The latter would have been devastating for the local economy, because banks would not lend money for developments if cyclone damage coverage was unavailable, Mr. Cloney said.

The industry decided instead to design and introduce construction codes so buildings could withstand violent weather. Mr. Cotterill said QBE, which operates in Fiji as Queensland Insurance (Fiji) Ltd., was the major company leading the push for construction standards. It now has a 45% market share there.

The standards were drawn up with help from the Fijian government and Australian groups experienced in dealing with cyclones, Mr. Cloney said.

The Fijian insurance industry insisted on engineering reports for all commercial buildings seeking cyclone and windstorm coverage, he said. Only those that implemented building improvements recommended in an engineer's report were able to get insurance.

Buildings that did not meet the standards were insured offshore, mainly in Australia, Europe and the London market, Mr. Cotterill said.

—By Kate McIlwaine

INTERNATIONAL

Sea erosion

Continued from page 17

the damage assessments of the surveyors and other experts. The actual cause of the catastrophe could determine whether the insurers are liable for the loss.

According to a spokesman for the Assn. of British Insurers, insurers are not liable for damage caused by sea erosion. "That is an uninsurable risk because it is inevitable, especially on this part of the coast," he explained. "But the hotel could well be covered for subsidence, and so (insurers) could be liable if it is decided that that is the cause."

Michael Clements, technical services director of the Scarborough County Council, told local reporters soon after the hotel disappeared off the edge of the cliff that the cause was "definitely landslip and not sea erosion." He would not comment further.

If Mr. Clements is correct, then CIGNA and the hotel's other insurers would be forced to pay up. And if other coastal properties are similarly at risk—like hotels, businesses and houses—then the region could become uninsurable.

"I would be very disappointed if one of my surveyors came back from here with a similar risk," said Kevin Pallett, marketing manager of the medium-size U.K. property underwriter Independent Insurance Col Ltd.

However, Keith Clayton, a geologist at the University of East Anglia in Norwich, said "there is no question that this disaster was caused by sea erosion." He called Mr. Clements' opinion that the event was caused by a landslide or subsidence as "rubbish."

This 37-mile section of the English coast is losing nearly 10 inches per year due to erosion from the sea, he explained. In addition, along the stretch of coast that is at risk, "there will be a similar event every six years for each 10 km (6.2 miles) of coastline, or one event a year for the whole stretch."

Professor Clayton did acknowledge, however, that the proximate cause of the hotel's plunge into the North Sea could well have been subsidence.

"This cliff has probably been ready to go for 50 years—anything could have pushed it. It probably had leaking drain pipes because it was Victorian (and) I believe they pulled up some trees in the garden last year which could have weakened the cliff. Or the wet weather could have caused it to subside," he said. BI

Nordic insurers

Continued from page 17

The Norwegian Finance Ministry said in a statement that three organizations that are part of a consortium underwriting the issues—the state pension fund, Folktrygfondet; food company Orkla; and U.S.-based investment group Tiger Management—may hold a maximum of 15% of UNI Storebrand for up to three years but with restricted voting rights.

UNI Storebrand's small shareholders have charged that associates of Tiger Management include individuals who were directors of UNI Storebrand at the time of the Skandia stock acquisition.

Norwegian Finance Minister Sigbjorn Johnson has been under protracted questioning in Parliament over the Skandia affair. In a written answer to the parliamentary Finance Committee, Johnson confirmed that the Skandia acquisition plan had gone ahead prior to the Finance Ministry granting UNI Storebrand permission to do so under the country's currency regulations.

Mr. Imbach says UNI Storebrand shareholders are now demanding the refinancing program be conducted under the rules of the Oslo Stock Exchange. Stock exchange rules should give existing shareholders the right to subscribe to 100% of the new issue rather than just 50%. He adds that this and the small shareholders' opposition to the writing down of the value of UNI Storebrand shares has been vindicated by the company's improved results for the first quarter (*BI*, May 31).

But the small shareholders' position is criticized by Mike Wheelhouse, insurance analyst at London-based stockbroker Nomura International, who believes the shareholders are accustomed to being a "little bit mollycoddled." He says the shareholders should agree to the refinancing because "by some miracle" the UNI Storebrand shares they hold still have some value. Hafnia Holding shareholders, on the other hand, lost everything.

"At least Storebrand is doing things properly and going for a big capital increase in one go. That's what Hafnia should have done last year and not just gone for 1 billion Danish kroner ($159 million at the appropriate exchange rate) in the domestic market."

Mr. Wheelhouse says he feels very little sympathy for the protesting shareholders because they could have sold their shares at a high price if they had opposed the Skandia acquisition plan from the outset. BI

EEOC guidelines

Continued from page 1

Some experts interpret this provision to mean that if an employer imposed, for example, a $25,000 limit on coverage for AIDS, a similar limit would have to be imposed on medical conditions with comparable costs.

"If you limit, for instance, AIDS coverage and don't limit treatment for heart conditions and the costs are comparable, the EEOC would challenge the practice as one that was motivated by discrimination rather than saving money," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Other benefit consultants, though, say it may be difficult to compare different disabilities and aren't quite sure how this defense would work.

"How do you compare AIDS, which doesn't have a cure, to other medical conditions? I think litigators will make all kinds of arguments and there will be battles of dueling actuaries," said Linda Laarman, a principal with William M. Mercer Inc. in Washington.

Other defenses against charges of discrimination under the ADA are more clear-cut.

For example, a plan with a $25,000 limit on a specific medical condition would be permitted if an employer could satisfy a two-pronged test: Without the limitation, the health plan would have become insolvent *and* there was no non-discriminatory health care plan change that could have avoided the insolvency.

Another accepted defense to a challenged plan limitation would be that there was no non-discriminatory alternative and that the limitation was necessary to prevent an "unacceptable" change in coverage provided by or premiums charged by the plan.

Examples of unacceptable changes would be "drastic" increases in employee premium or cost-sharing requirements that would make the plan either effectively unavailable to a significant number of employees or make the plan so unattractive that only employees anticipating big medical claims would apply for coverage.

A health plan also would be considered unattractive if an employer would not be able to compete in recruiting and maintaining workers due to the superiority of other health plans in the community.

'How do you compare AIDS, which doesn't have a cure, to other medical conditions? I think litigators will make all kinds of arguments and there will be battles of dueling actuaries,' says Linda Laarman, a principal with William M. Mercer Inc.

In addition, an employer could deny coverage for treatments of no medical value. However, an employer would violate the ADA if it denied coverage for a specific treatment with no medical value, but covered treatments for other conditions that also have no medical value.

The EEOC guidelines make clear that employers can offer more generous benefits to employees than to their dependents without violating the ADA.

An employer, the EEOC says, could cap health care benefits at $100,000 for employees, but impose a $50,000 medical plan cap on the employees' dependents.

But other practices would be banned outright. An employer's decision on whether to hire an individual could not be based on concerns about the impact of that person's disability on the cost of the health plan.

In addition, employees with disabilities would have to have the same access to health care coverage as employees without disabilities.

Under the guidelines, an employer would be liable for violations of ADA even if the violations were caused by its health care plan administrator, insurer or health maintenance organization.

EEOC officials say it was important for the commission to issue guidelines now rather than wait to see how comprehensive health care reform would address discrimination issues.

"These are life-and-death issues. We just cannot wait until health care reform is adopted and we have a health insurance system for the whole country," said Rosalie Gaull Silberman, an EEOC vice chairman. BI

EEOC seeks to compel plan to cover AIDS

By MARY E. PFLUM

NEW YORK—The U.S. Equal Employment Opportunity Commission is suing to block a self-insured multiemployer plan's attempts to deny coverage for HIV and AIDS treatment, alleging it violates the Americans with Disabilities Act.

The suit, filed Thursday in U.S. District Court in New York, comes on the heels of interim enforcement guidelines issued by the agency dealing with the application of the ADA to disability-based distinctions in group health insurance plans (see story, page 1).

The EEOC lawsuit, which was filed on behalf of AIDS patient Terrence Donaghey Jr., names as defendants the Mason Tenders District Council Welfare Fund and three of its trustees, Mason Tenders Local 23, Mason Tenders District Council of Greater New York, Associated Brick Mason Contractors of Greater New York and Building Contractors Assn. Inc.

James Neely, EEOC deputy general counsel, explained at a press conference last week in New York that the commission's suit is based on the EEOC's determination that the Mason Tenders Welfare Fund provided no actuarial justification for excluding AIDS coverage for Mr. Donaghey, a union member covered under the plan.

"We are seeking to modify (Mason Tenders') disability plan, and we're also seeking compensation for punitive damages," Mr. Neely said.

The suit is 'an attempt by that federal agency to raid the treasury of the welfare fund,' says the fund's Mr. Levin.

Roger Levin, counsel to the Mason Tenders Welfare Fund, contends the EEOC lawsuit has no legitimate basis. The fund filed suit against the EEOC on March 1, arguing that the self-insured plan is governed by the Employee Retirement Income Security Act, not the ADA (*BI*, March 8).

That lawsuit came after a January ruling by an EEOC official —in response to a complaint filed by Mr. Donaghey—that the fund's exclusion of coverage for human immunodeficiency virus and acquired immune deficiency syndrome is discriminatory (*BI*, Feb. 15).

"(The suit) is nothing but an attempt by that federal agency to raid the treasury of the welfare fund in order to provide specified medical benefits to only a few while destroying the ability of the welfare fund to provide the greatest level of benefits to the largest number of participants," said Mr. Levin, who also is a managing partner with Levin & Weissman in New York.

The fund's March complaint says coverage for HIV and AIDS was discontinued in 1991—before the ADA became law for most employers—because of "deteriorating economic conditions" in the construction industry.

Mr. Donaghey, who is currently uninsured, said he is pleased with the EEOC's action and looks forward to reinstated health care benefits. "Right now, I'm just tired and pleased with the decision. We'll see what happens." BI

Spencer fund scholarships awarded to 10

The Spencer Educational Foundation Inc. has awarded 10 scholarships to students of risk management, insurance and employee benefits.

The 1993 recipients of the $10,000 scholarships are: David W. Batten and Sharon L. Taylor of Georgia State University; Larry L. Colquitt and Susan E. Hurt of the University of Georgia; Lisa A. Helsing of the University of Wisconsin at Madison; Jean L. Kahwajy of Stanford University; Angela C. Matherly of Appalachian State University; Lois M. Miller of Middle Tennessee State University; Christine L. Morgan of Temple University; and Marc B. Samuels of the University of Texas.

In addition, the second annual Holwerda Award has been presented to Jody S. Bergerud of the College of Insurance in New York. The Holwerda Award, this year in the amount of $2,672, is in memory of the late Joseph G. Holwerda, who was a risk management executive with Deerfield, Ill.-based manufacturer Premark International.

The Spencer Foundation has also made grants to the general scholarship funds of several colleges and universities. The awards are drawn from a matching funds program supported by Risk & Insurance Management Society Inc. chapters.

The Spencer Foundation was founded in memory of the late Robert S. Spencer, a former RIMS president. Since 1980, 140 scholarships have been awarded to students from 40 colleges and universities. BI

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ELIC rehabilitation.

However, the remaining muni-GIC holders—which represent more than a third of ELIC's uncovered liabilities, or $1.65 billion—and bond underwriters still object to the plan.

They also are continuing to press their motion to rescind the sale of ELIC's junk bond portfolio to a group of French investors, alleging the bonds now are worth about $2 billion more than the original $3.2 billion purchase price.

Despite the settlements reached last week, Judge Lewin has yet to rule on several aspects of ELIC's new rehabilitation plan. In addition to the issue of the junk bond valuation, he has not yet ruled on the policyholder status of GICs issued after a 1989 state law took effect making them non-insurance.

In addition, ANVEL was given court approval to present a friend-of-the-court brief explaining the group's objections to five points in the new plan.

Hearings on the revised rehabilitation plan are expected to continue into this week.

Under the settlements reached last week, policyholders representing nearly two-thirds of ELIC's $4 billion in uncovered liabilities will receive 78.7 cents on the dollar. That is substantially less than the 89 cents on the dollar offered during the bidding process, but is more than the 70 cents on the dollar that most policyholders had been getting since the rehabilitation proceedings began.

Applause filled the court when Judge Lewin approved the Texas Commerce Bank settlement Wednesday, ending the long fight between the Insurance Department and the bank over its right to claim payments from ELIC.

"We are very gratified that we have been able to not only establish the policyholder priority of TCB's GIC but also to confer significant additional financial benefits on all policyholders," said Christine Franklin, co-counsel for Texas Commerce Bank with Thelen, Marrin, Johnson & Bridges in Los Angeles.

She pointed to a California Court of Appeal's decision that forced ELIC's rehabilitator to adopt an asset valuation method that increased funds available to all policyholders. Prior to this ruling, the Insurance Department had proposed ELIC be valued as if it were sold at a fire sale after its April 11, 1991, seizure.

"The settlement will give TCB the benefits of whatever is ultimately determined to be the most advantageous treatment for similar policyholders without the costs of continued litigation," Ms. Franklin added.

But, attorneys representing holders of $1.65 billion in muni-GICs objected to the settlement offer last week, calling it a "blackmail device."

"I think that it is in bad faith. I think it is extortion. I think that it's not the conduct of a fiduciary," said Phillip Warden, an attorney with Pillsbury, Madison & Sutro in San Francisco.

"For this court to put its imprimatur upon this kind of a blackmail device, I think, is totally inappropriate," he asserted.

But Judge Lewin disagreed, pointing out that the additional payment granted under the settlement was akin to a defendant extending a settlement offer to a plaintiff.

"I thank you for the observation, but I reject it," the judge told Mr. Warden.

"A private party is at liberty to do what is not a violation of law to entice a person to reach a settlement," Judge Lewin said, adding that "if Aurora has a fund to 'bribe' people to settle, there's nothing wrong with that."

The Texas Commerce Bank settlement is subject to a vote of bond holders at a special meeting to be called within 45 days.

Texas Commerce Bank-El Paso is the holder of a GIC issued by ELIC that serves as the sole source of payment of approximately $200 million in El Paso Housing Finance Corporation Securitized Multifamily Housing Revenue Bonds issued in October 1986. The bonds are in default.

The settlement provides that the bank will immediately receive 70% of its contract value at the time ELIC was seized, or $31.6 million, plus a $3 million advance on the expenses it incurred in the ELIC proceedings.

ELIC had made no payment on the Texas Commerce Bank muni-GIC since the insurer was placed in conservation on April 11, 1991.

In addition, the settlement includes a "most favored nation" clause that allows the bank to receive a pro-rata share of any additional amounts that other muni-GIC or single-premium annuity contract holders may obtain through litigation.

Meanwhile, negotiations are continuing on details of settlements with CoCARE, a group of employers that terminated pension plans and bought ELIC annuities for plan participants, and also with a group of employers that still hold group annuity contracts purchased from ELIC.

Among the sticking points are the policyholder status of GICs issued after 1989, when Section 10541 of the California Insurance Code made such funding arrangements "non-insurance."

Judge Lewin said he likely will rule on the settlements without deciding the post-1989 GIC issue because the commissioner has the discretion to make payments to these GIC holders regardless of their status.

Furthermore, legislation being considered by the Senate Insurance Committee that would extend to the post-1989 GICs the same policyholder status granted to the pre-1989 GICs could make the issue moot (*BI*, May 17).

The Washington-based National Structured Settlements Trade Assn. also agreed not to object to the rehabilitation plan.

Several member insurers have collectively contributed about $100 million to make whole recipients of annuities the insurers had purchased from ELIC to fund structured settlements, said Executive Vp Randy Dyer.

After putting up some initial resistance, ANVEL, a group representing 1,500 individual annuitants, agreed to drop its opposition to the plan.

However, no definitive settlement has been reached, said Maureen Marr, coordinator of the Los Angeles-based group.

"There is a group that is settling and a group that is not objecting, and ANVEL falls into the latter," she said.

In court Wednesday, ANVEL attorney David Mark Balabanian, with McCutchen, Doyle, Brown & Enersen in San Francisco, argued that the group should be allowed to explain its objections to the plan without jeopardizing its members' chances for a share of the Aurora settlement offer.

Judge Lewin agreed, granting him two days to present testimony.

But this angered Aurora attorney Kenneth Heitz of Irell & Manella in Los Angeles, who threatened to withdraw the settlement offer if ANVEL were allowed to present its objections.

This spurred ANVEL to accept the settlement offer and drop its objections.

Afterwards, though, Judge Lewin granted Mr. Balabanian permission to present the group's objections in a friend of the court brief. BI

SunAmerica to buy shares in Executive Life successor

LOS ANGELES—SunAmerica Inc. plans to buy into the successor company to Executive Life Insurance Co. after a court approves its new rehabilitation plan.

Under terms of an agreement announced Thursday, SunAmerica will purchase one-third of the stock of New California Life Holdings Inc., parent company of Aurora National Life Assurance Co., upon the closing of its sale to the French investor group led by merchant bank Altus Finance.

Los Angeles-based Broad Inc., SunAmerica's parent, was one of the eight investor groups that had offered to purchase ELIC during the competitive bidding process initiated by California Insurance Commissioner John Garamendi (*BI*, Nov. 11, 1991).

While SunAmerica will hold a stake in New California, it will not have a role in the new insurer's operations, said Eli Broad, SunAmerica's chairman, president and chief executive officer.

—By Joanne Wojcik

NAIC hearing

Continued from page 1
piled by the General Accounting Office and released at the hearing was less critical of the NAIC's efforts than previous GAO reports. But while the GAO found that the regulation and accreditation program has grown more effective over the past three years, "there's a lot of improvement that needs to take place," said Assistant Comptroller General Richard L. Fogel.

The GAO report cited three specific problems with the NAIC's accreditation program: "permissive interpretation" of NAIC standards; resistance by some regulators and lawmakers to the program; and "inadequate criteria" for evaluating how well a state analyzes an insurer's financial statements.

"While inherent limits in NAIC's ability to enforce standards and rules raise doubts about its ultimate ability to achieve effective state regulation, we believe NAIC's goal of achieving a national system of insurance solvency regulation is worthwhile, and that its efforts can be beneficial. There's no doubt about it," said Mr. Fogel.

"We will gladly stack our record of consumer protection" against the federal government's record in policing the savings and loan industry, said Virginia Insurance Commissioner Steven Foster, who is also NAIC president. Mr. Foster said NAIC was "most disappointed" when the GAO declined the NAIC request to help the commissioners' group in implementing the accreditation program.

"Any fair-minded look at our record must lead to the conclusion that state regulation works," said Mr. Foster.

When Rep. Sherrod Brown, D-Ohio, asked why the state regulatory system had not managed to shut down Mr. Miro's operations, Mr. Foster replied that he would not defend the actions of regulators who had been Mr. Miro's partners in crime. Rep. Brown then asked how the commissioners could explain a system that allowed people like Mr. Miro to operate.

Alaska Insurance Commissioner David Walsh, who is vp of the NAIC, said laws are passed to keep honest people honest. "Mr. Miro does not fall into that category," he said. He noted that Mr. Miro had violated federal as well as state laws and described Mr. Miro as nothing more than a con man seeking a lighter sentence.

Rep. John D. Dingell, D-Mich., chairman of the Energy and Commerce Committee and its investigations subcommittee, grew angry and accused Mr. Walsh of failing to answer the question. Rep. Dingell wants the current state regulatory system to be blended with a federal regulatory system described in H.R. 1290, the Insurer Solvency Act of 1993, which Rep. Dingell introduced earlier this year (*BI*, March 15).

He asked Mr. Walsh how many states initiated actions against Mr. Miro. When Mr. Walsh said he didn't know, Rep. Dingell retorted that "the states were absolutely helpless" in the face of Mr. Miro's schemes.

"It was the feds who caught Mr. Carlos Miro. Tell us one thing the states did," thundered Rep. Dingell.

When Florida Insurance Commissioner Tom Gallagher attempted to contrast the general record of state insurance regulation with the federal failure in the case of Bank of Credit & Commerce International, Rep. Dingell informed him bluntly that the subcommittee was talking about insurance, not banks.

Interrupting members of the NAIC panel repeatedly, Rep. Dingell kept asking witnesses, "Tell me one thing the states did" to end Mr. Miro's activities. Finally, the chairman announced that he had to cast a vote in the House and advised his witnesses to think long and hard about answering his question.

After the subcommittee reconvened, Mr. Foster said some state receivers of Mr. Miro's failed insurance companies had attempted to obtain information and cooperation from Mr. Miro. He added that the NAIC welcomes cooperation from Congress in passing federal anti-fraud statutes that would make prosecution of insurance-related criminal activity easier and would allow the NAIC to review and qualify alien insurers and reinsurers wishing to do business in the United States.

Rep. Dingell continued to hammer at the witnesses. "You were incapable of producing the willing or unwilling cooperation of Mr. Miro," he said.

When Mr. Gallagher began describing how Florida dealt with a couple who had driven an insurance company and a bank they owned into insolvency, Rep. Dingell grew livid. He told the Florida insurance commissioner that if he wanted to talk about banks, there was a "committee across the hall" that had jurisdiction over banks and offered to give Mr. Gallagher the committee's telephone number. BI

'Small' claim results from racehorse's death

LONDON—Prairie Bayou's death after the June 6 Belmont Stakes likely will have a greater impact on horse racing fans than on bloodstock insurers.

Because the horse was a gelding and unable to produce stud fees for owner John Ed Anthony, the claim filed last week following the horse's death is only between $300,000 and $500,000.

The bloodstock coverage was placed in the United States by Louisville, Ky.-based agency Harris & Harris of Kentucky Inc. Harris & Harris worked with specialist Clay Ward Agency in Paris, Ky., to place the coverage in London. The London coverage was placed through specialist bloodstock broker Hughes-Gibb & Co. Ltd., a subsidiary of Willis Corroon P.L.C. The coverage is written by the London office of Italian insurer Assicurazioni Generali S.p.A.

Prairie Bayou, after finishing second in this year's Kentucky Derby and first in the Preakness, buckled while running in the Belmont Stakes and suffered compound fractures of his left foreleg. He was given a lethal injection after the race.

The deaths or disappearances of other horses have cost insurers far more because of projected values in terms of stud fees.

For example, Swale was insured for $14.5 million at the time of his death, though his projected value as a stallion was between $40 million and $50 million. He died shortly after he won the 1984 Kentucky Derby and Belmont Stakes (*BI*, June 25, 1984).

—By Stacy Shapiro

DuPont ordered to disband panels

WASHINGTON—The National Labor Relations Board has ordered E.I. DuPont de Nemours & Co. to disband seven worker-management safety committees that the labor board says constitute illegal labor organizations.

The Chemical Workers Assn., a union representing employees at DuPont's plant in Deepwater, N.J., claimed that the committees at the facility duplicated the union's safety and fitness activities and that DuPont refused to bargain with the union.

Wilmington, Del.-based DuPont has not decided whether to appeal the order, issued earlier this month, to the U.S. District Court of Appeals, a spokeswoman said.

DuPont has no plans to disband similar committees in place at most of its other facilities, but it is evaluating them to see if they comply with NLRB recommendations, she added.

—By Sara Marley

Managed care

Continued from page 3

The key to generating savings from precertification or a PPO, even in states that permit employees free choice of providers, is encouraging managers to direct injured employees to networks whenever possible.

"It's important to train managers and line supervisors to channel people to preferred providers. In an emergency situation, it's very important that the on-site supervisor knows about preferred providers, because the injured worker isn't thinking about who the doctor is. The injured person is only worried about getting treatment quickly," Mr. Miccolis said.

Coordination of workers comp and group health care benefits—used by only 39% of the employers, or the second-lowest among the 24 initiatives surveyed—received the highest marks in terms of being an effective cost control technique. Eighty-nine percent of the employers that coordinate workers comp and group health programs rated that technique as effective.

The reasons why employers don't coordinate workers comp and group health care benefits vary, but can include lack of familiarity with the concept or lack of cooperation between the departments responsible for managing workers comp and group health care benefits.

Mr. Miccolis recommended employers encourage cooperation between workers comp and employee benefit personnel by pushing "a team approach."

"It's important to get the risk manager, human resources director, employee benefits person, the CFO, the safety director, the medical director and actual operators around the same table," Mr. Miccolis said.

While employers ranked many of cost containment strategies—including PPOs, precertification and medical bill audits—as nearly as effective as workers comp-group health plan coordination, two much publicized programs received low ratings. Only 60% of those with vocational rehabilitation programs rated them as effective, while only 53% thought wellness programs were effective.

Another method employers use to reduce workers comp costs is improving oversight of vendors, including insurers, brokers, third-party administrators, managed care networks, case managers and utilization review companies.

While most of the respondents track vendor performance in some way, more than 30% do not track the performance of their case management company, utilization review firm or managed care network.

"Establishing written vendor performance objectives, tracking performance and using performance-based contracts, common in non-occupational health benefit programs, is essential to making vendors an active, accountable part of each employer's cost-containment program," said Dan McAdams, another Towers Perrin consultant.

In addition, employers should improve pre-injury communication with employees about the workers compensation system.

Employee misinformation about workers comp "is monumental" and often encourages them to seek an attorney's help, Mr. Miccolis said. Active and frequent communication will likely be able to reduce the threat of litigation and keep attorney costs at a minimum, he said.

Towers Perrin reported that employers use of other initiatives not directly related to managed care also increased in the past two years, although not as dramatically. They include early return-to-work programs, vocational rehabilitation and claims administration audits.

"Generally, employers who take a holistic approach to workers compensation cost control, by examining their entire program to see which cost-control initiatives will be the most effective in which areas and then measuring the effectiveness of these initiatives, will have the most meaningful results," Mr. Miccolis said.".

As a result of having taken cost-containment steps, companies are more optimistic about their ability to control workers comp costs than they were two years ago, the survey reports. In 1993, only 23% believe workers comp costs will be out of control in five years, compared with 30% in 1991.

Separately, Towers Perrin found that 53% of the 99 Fortune 1,000 companies surveyed favor merging the workers comp and group health care systems as contemplated by President Clinton, though only 32% consider it even somewhat likely that Congress will pass such a proposal.

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Free copies of "Regaining Control of Workers Compensation Costs" will be available after June 28. Call 800-525-6741.

Florida reports a big drop in costs in managed work comp care pilot

By LOUISE KERTESZ

First-year results of a pilot program in Florida show that workers comp claims costs under a managed care plan were 38.5% lower than costs under a fee-for-service plan.

The program, authorized by the Florida Legislature, was designed to evaluate the application of managed care to workers compensation (*BI*, Sept. 28, 1992).

Conclusions "must be regarded as preliminary and tentative," cautioned Milliman & Robertson, the consulting firm that evaluated two projects in the program.

In the first project, CAC-Ramsay Inc., a health maintenance organization in Coral Gables, Fla., provided medical care to state employees in South Florida who were injured on the job. Half of the 17,000 state employees received medical care in the HMO. The other half—the control group—received medical care under a fee-for-service plan.

In the second project, medical care was provided for on-the-job injuries to a group of 7,500 privately employed individuals in the Tampa-St. Petersburg area through a Travelers Insurance Co. PPO.

The Travelers project had no specific control group, but "there were a sufficient number of claims receiving treatment outside of the network to act as an internal control group," the M&R report states. Data on self-insured employers were also used as an external control group.

The report is based on almost 2,200 individual claims representing all the workplace injuries during the program's first year.

The findings include:

- After accounting for Ramsay's administrative fees, the HMO reduced total workers comp claim costs by an estimated 38.5% over the fee-for-service plan.
- "Little difference" in average direct claims costs was found between claims from the Travelers PPO network, from those that had the PPO option but did not use it and from self-insured plans.
- Participants in both programs "were satisfied with the overall quality of care."

M&R cautions that its conclusions are tentative for various reasons. Among them, "the long-duration claims which generate the majority of workers comp costs" are not fully evident in first-year results.

Also, "there were significant differences between the occupational composition of the Ramsay and Travelers programs, which may influence the size of the observed savings," M&R said.

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To obtain the "2nd Interim Report to the Florida Legislature—Workers Compensation Managed Care Pilot Project," send a written request with a $20 check, payable to the State Treasurer of Florida, to the Insurance Department, P.O. Box 6100, Tallahassee, Fla. 32314-6100.

Reform plan details

Continued from page 2

nual deductible of about $200 for individual coverage and about $400 for family coverage.

Mr. Magaziner did not lay out copayment charges, but did say that the annual out-of-pocket limit in the indemnity plan would be about $2,000 for individual coverage and about $3,000 for family coverage, said the HCLC official, who declined to be identified.

Mr. Magaziner did not indicate how much the deductibles or copayments would be in the HMO and PPO options. HMOs, though, typically do not charge deductibles, while copayments are usually much lower compared with indemnity plans. PPO charges vary depending on whether an individual obtains services from network providers.

Employers would pay about 75% of the premium, while employees would pay about 25%. Mr. Magaziner didn't specify if this level of cost-sharing would be the same for individual and family coverage.

The Clinton administration has yet to decide many other details—critical ones—of its health care reform plan, Mr. Magaziner said. Decisions have yet to be made on how universal coverage will be financed, the size and regulatory power of health care purchasing alliances and whether there will be any price controls imposed on providers.

The administration, though, is considering whether to give individual states the option of adopting "enterprise liability." Under this concept, injured patients only could recover medical malpractice damages from health care plans, leaving providers immune from liability.

The enterprise liability proposal has received a "mixed" reaction, Mr. Magaziner told the group in explaining why states could—but may not be required—to adopt it. BI

Update

Reinsurers awarded $37 million

Continued from page 2

ness for the reinsurers through the Graham Watson division of Cameron & Colby Inc., a now-defunct unit of ITT Hartford (*BI*, Aug. 17, 1992).

Under reinsurance treaties in effect from 1980 to 1983, Graham Watson was to produce business from Hartford units and from other primary insurers.

In his June 7 ruling, however, U.S. District Court Judge Edward F. Harrington found that Graham Watson did not underwrite on a facultative basis and that the division accepted most of its risks through managing general agents and intermediaries, instead of directly from insurers as intended.

ITT Hartford will appeal, a spokesman said.

High court upholds bank law

WASHINGTON—National banks with branches in towns with fewer than 5,000 people can continue to sell insurance in those towns after a unanimous Supreme Court ruling.

The high court determined that Congress did not repeal Section 92 of the National Bank Act two years after it was implemented in 1916. The decision was based on the court's finding that the placement of quotation marks in Section 92, the section that granted small-town banks the authority to sell insurance, were in error. The Independent Insurance Agents of America alleged in a lawsuit that Congress in 1918 called for the repeal of sections of the act appearing within quotation marks.

"In this unusual case, we are convinced that the placement of the quotation marks in the 1916 act was a simple scrivener's error. . . .The true meaning of the act is clear beyond question, and so we repunctuate," Justice David Souter wrote for the court.

The IIAA and others filed suit against the U.S. Comptroller of the Currency after it allowed a national bank in Oregon, operating under the small-town exemption, to also sell insurance nationwide.

The high court's June 7 decision only held that Section 92 is still in effect. The underlying issue of whether small-town banks can issue insurance nationwide was remanded to the District of Columbia U.S. Circuit Court of Appeals.

Briefly noted

States may give policyholders' claims and the costs of **liquidating an insolvent insurer** priority over claims filed by the federal government in insolvency proceedings, the U.S. Supreme Court ruled Friday. But the federal government must have priority over other creditors, like state and local governments, the court said. . . .Nebraska last week enacted a sweeping **workers comp reform bill** designed to lower costs for employers with good records while improving benefits for injured workers. . . .The **AFL-CIO** is preparing to launch a multi-million-dollar lobbying campaign for health care reform once it determines whether it will support the Clinton administration's proposal. . . .A U.S. magistrate cut to $222,000 from $572,000 the first job discrimination jury verdict under the **Americans with Disabilities Act** because of a $200,000 cap on compensatory and punitive damages against small firms. He also ordered Chicago-based AIC Security Investigations Ltd. and its president to pay $22,000 in back wages (*BI*, March 22). . . .**Maurice R. Greenberg**, chairman and CEO of American International Group Inc., has been elected chairman of the United States-China Business Council, a non-profit group of U.S. companies with business interests in China. . . .Standard & Poor's Corp. has raised the claims-paying ability of **Allstate Insurance Co.** and its pool members to AA from AA- and removed the insurer from the CreditWatch. In addition, S&P gave a preliminary A rating to the newly formed Allstate Corp. . . .Edward K. Trowbridge will retire as chairman and CEO of **Atlantic Mutual Cos.** in November. Kenneth J. Gorman, president and COO, is expected to succeed Mr. Trowbridge. . . .Maryland has enacted a law that requires insurers and HMOs to cover **treatment for mental illness** on at least the same basis as the majority of comparable benefits available under a health care policy. . . .**National Union Fire Insurance Co. of Pittsburgh, Pa.**, is not obligated to pay an estimated $20 million to defend investor lawsuits filed against Charles H. Keating and other officials of the failed Lincoln Savings & Loan, the 9th U.S. Circuit Court of Appeals ruled. Separately, a federal jury has ruled that National Union must pay $12 million in damages to American Medical International Inc. for acting in bad faith when it arranged a settlement over a legal dispute with a major stockholder of AMI in 1991. . . .The California Supreme Court has let stand an appellate court ruling in *Wong vs. State Compensation Insurance Fund* that workers comp insurers must defend employers against **wrongful termination claims**. . . .**Blue Cross & Blue Shield of Virginia** will change its name to Trigon Mutual Insurance Co. later this year. . . .Ronald J. Bornhuetter has been elected chairman of **NAC Re Corp.**, replacing Donald Kramer, who has retired (see story, page 1). Mr. Bornhuetter will continue to serve as president and CEO. In addition, Thomas C. Jones was promoted to COO. . . .A group of California employers is suing the **State Compensation Insurance Fund**, alleging the work comp insurer has overcharged employers more than $500 million a year by overreserving. . . .**Lloyd's of London** is making it more difficult for members to call extraordinary general meetings, now requiring 1,500 members' signatures on a petition, rather than 100. . . .The National Council on Compensation Insurance cut a request for a **workers comp premium increase in Oklahoma** to 16.9% from 27.7% after the state enacted a reform law. The law, among other things, reduces some permanent partial disability benefits and requires employees to provide more evidence to prove cumulative trauma claims. . . .**Legion Insurance Co.**, a unit of Mutual Risk Management Ltd., has received an A- rating—its first letter rating—from A.M. Best Co.

Industry will benefit from FAS 113

By MYRON M. PICOULT

Special to Business Insurance

LAST DECEMBER, the Financial Accounting Standards Board issued a new statement, FAS 113, that established new generally accepted accounting principles for reinsurance. The rules apply to contracts issued after Jan. 1 and include several major changes.

Simply put, reinsurance contracts are now subject to more stringent criteria in order to qualify for reinsurance GAAP. These new rules further curtail the financial flexibility enjoyed by many insurance companies. Our perspective has been that financial reinsurance contracts have favorably distorted individual insurers' numbers, undermining sound underwriting and prudent risk management.

We estimate that several billion dollars of financial reinsurance have been written annually. A chunk of this volume may now be issued in a more traditional manner by onshore insurers. Furthermore, the attendant pressure on primary insurers from not being able to finagle with their numbers adds to their financial distress and should increase their need for reinsurance as they seek to adjust their risk profiles downward.

To date, however, we must admit that notwithstanding the issuance of abominably compromised first-quarter underwriting statistics, the lunatic fringe still prevails in the casualty pricing arena.

The impact FAS 113 is having on the marketing of financial reinsurance to domestic primary insurers is best exemplified by the recent initial public offering of Zurich Reinsurance Centre Holdings Inc., which in effect rebundled a significant portion of Centre Reinsurance Cos. (Bermuda), which was a major purveyor of such covers (*BI*, March 15).

The obvious question is why FASB got involved in reinsurance accounting. We believe that several factors were involved, including the following:

- GAAP standards and what appears to have been some sloppy interpretations of accounting guidance have led to inconsistent accounting practices within the industry. Thus, comparing individual company financials became a nightmare.
- Some industry observers were becoming increasingly concerned that the growing use of financial reinsurance was obfuscating true operating trends.
- There have been some long-standing concerns about the adequacy of reinsurance accounting and reporting among regulators, the Securities and Exchange Commission, Congress, rating agencies and analysts. Some high-profile failures and indications that reinsurance was partly at fault further fanned the flames.

The following changes were made in the new standards:

- Ceding enterprises are no longer able to recognize a gain immediately on retroactive contracts (covering past insurable events). The gains must be deferred and amortized over the expected claims settlement period.
- Significant additional disclosures are required with respect to the purpose, nature and effect of the cedant's reinsurance programs. Insurers are also now required to disclose concentrations of credit risk arising from reinsurance receivables and recoverables.
- Reinsurance recoverables must be reported as an asset on the balance sheet and the entire reinsured claim liability (including recoverables on outstanding claims and incurred-but-not-reported reserves) must also be reported. The two may no longer be offset.
- Retroactive and prospective provisions within the same contract must be accounted for separately. If this cannot be done, the entire contract must be accounted for as retroactive.
- Reinsurance has been more effectively defined for accounting purposes to exclude transactions that either fail to transfer timing and underwriting risk or that do not subject the reinsurer to the reasonable possibility of a significant loss from the insurance risk assumed. Such transactions are considered financing.

The new FASB rules do not apply to statutory accounting. As previously noted, they apply only to GAAP financial. However, we would be surprised if the National Assn. of Insurance Commissioners did not adopt all of the most important facets of the FASB standards because the new FASB rules are generally more stringent than current statutory accounting rules.

We believe the new FASB rules will help restore integrity to insurance company financial statements and effectively address concerns about financial manipulation. Concomitant with this, it should reinforce the validity and economic substance of reinsurance.

Furthermore, the rule changes should result in more emphasis on the importance of sound underwriting and prudent risk management and will perhaps bring some needed underwriting discipline to the primary and reinsurance industries.

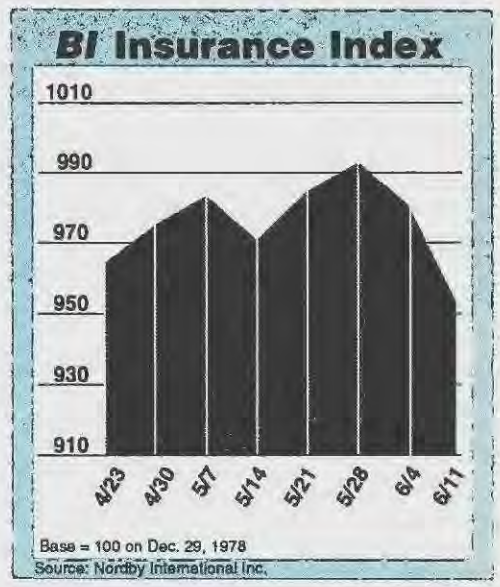
We realize that these new rules will cause some insurance companies to lose some financial flexibility due to the tightening of risk transfer guidelines and the new accounting rules for retroactive reinsurance. This is a worthwhile sacrifice, considering the state of the business. Indeed, the strong insurers have nothing to fear.

We also realize that the gross reporting statute could create some undue focus on potential credit risk and reinsurance leverage that could be subject to misinterpretation. Once again, this is a risk that has to be taken to return integrity to balance sheets, and the stronger insurers should have nothing to fear. A little more effort in terms of explanations and simplistic reporting should cover the bases.

As investors review recasted balance sheets, it will become clear that reinsurance recoverables are the second-largest asset for the property/casualty industry.

Hence, much more attention is going to have to be paid to collectability. Most insurers have negligible allowances for uncollectable reinsurance. The flight to quality by reinsurance buyers is no accident. In fact, the coming implementation of risk-based capital standards will put even more focus on the issue. BI

Myron M. Picoult is managing director and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.



Insurance industry stocks continued to fall last week, as the *Business Insurance* Index tumbled 30.2 points to 952.3 June 11 from 982.5 on June 4. Advancing issues for the week were led by: HCC Insurance Holdings, up 9.8; Gainsco Inc., up 6.7; and Lawrence Insurance Group, up 6.1. Declining issues for the week followed: Seibels Bruce Group, down 17.7%; Phoenix Re Corp., down 10.2; and Chandler Insurance, down 9.1. The most active issue was Allstate Corp., 13.2 million shares traded. The *BI* Index was down 3.1%; the NYSE Composite was down 0.8%; the Standard & Poor's 500 was down 0.6%; and the Dow Jones 30 Industrials fell 1.1%.

British Issues

June 10 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	592	N/M	32.5	5.5	598—588	
Genl Accident	582	N/M	35.7	6.1	585—581	
Gdn Royal Exch	178	N/M	9.3	5.2	185—178	
Royal	284	N/M	6.7	2.3	292—284	
Sun Alliance	352	N/M	19.0	5.4	354—348	
Brokers						
Bradstock	121	14.2	6.8	5.6	121—121	
CE Heath	338	16.2	20.5	6.1	338—323	
Hogg Group	180	15.8	10.9	6.0	180—180	
JIB Group	189	18.7	10.0	5.3	189—189	
Lloyd Thompson	294	23.7	7.5	2.5	294—294	
Lowndes Lmbrt	342	13.5	16.8	4.9	343—342	
PWS Holdings	60	8.9	5.3	8.8	60—59	
Sedgwick Grp	180	21.7	8.0	4.4	180—173	
Steel Brrl Jones	230	13.5	17.7	7.7	230—223	
Willis Corroon	202	18.9	8.8	4.3	202—197	

Source: Philip Olsen, London

BI Industry Stock Report

JUNE 7, 1993 THROUGH JUNE 11, 1993

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Acordia Inc.	NYS	20.25	4.52	-5.81	24.75	15.13	222	0.44	2.17	13	7.01	2.89
Alexander & Alexander	NYS	25.88	0.00	-2.36	28.88	21.00	113	1.00	3.86	22	10.00	2.59
E.W. Blanch Holdings Inc.	NYS	18.00	-4.64	N.A.	20.00	17.75	139	0.00	0.00	-	10.00	1.80
Gallagher Arthur J. & Co.	NYS	31.38	-4.20	11.06	37.38	21.00	162	0.72	2.29	19	6.35	4.94
Hilb, Rogal & Hamilton	NYS	13.75	0.92	-12.00	16.88	11.00	652	0.44	3.20	19	3.11	4.42
Marsh & McLennan	NYS	85.63	-4.33	-6.29	97.63	75.13	667	2.68	3.13	20	14.40	5.95
Poe & Brown	OTC	19.25	-2.53	14.93	21.25	11.25	25	0.40	2.08	34	2.64	7.29
BROKERS	AVERAGE		-1.5	-0.1					2.4	18		
INSURERS/REINSURERS												
ACE Ltd.	NYS	26.00	-6.31	-	32.00	26.00	1089	0.40	1.54	9	34.06	0.76
AEGON N.V.	NYS	46.75	2.47	12.31	49.38	34.00	25	2.94	6.29	8	34.06	1.37
Aetna Life & Casualty	NYS	53.75	0.47	15.59	55.88	38.00	1053	2.76	5.13	117	67.08	0.80
Allied Group Inc.	OTC	32.88	-6.74	3.54	45.50	20.75	167	0.76	2.31	7	11.29	2.91
Allmerica Prop. & Casualty	NYS	55.00	-1.12	8.91	60.38	34.75	42	0.44	0.80	5	40.44	1.36
Allstate Corp.	NYS	28.00	-2.18	N.A.	30.00	27.63	13154	0.00	0.00	-	-	-
American General	NYS	30.63	-1.21	7.46	33.25	22.63	1585	1.08	3.53	12	39.89	0.77
American Heritage Life Ins.	NYS	24.13	2.12	19.63	25.34	18.91	8	0.44	1.82	17	16.51	1.46
American Indemnity/Fin'l	OTC	15.00	3.45	150.00	15.00	4.75	157	0.08	0.53	8	14.43	1.04
American International	NYS	128.25	-0.97	10.56	132.75	84.25	1717	0.60	0.47	16	54.21	2.37
American RE Corp.	NYS	32.00	-6.23	-13.51	41.75	31.75	334	0.00	0.00	70	N.A.	N.A.
Aon Corp.	NYS	51.38	-0.48	-4.86	56.75	41.50	257	1.80	3.50	17	27.17	1.89
Argonaut Group	OTC	31.50	-4.55	3.28	35.25	26.00	48	1.00	3.17	10	21.70	1.45
AVEMCO Corp.	NYS	21.63	1.76	-7.49	27.88	18.50	9	0.40	1.85	25	7.33	2.95
Baldwin & Lyons Inc.	OTC	38.00	-3.80	4.11	41.00	29.25	2	0.48	1.26	9	30.85	1.23
Berkley W.R. Corp.	OTC	38.50	-4.94	-10.47	50.50	32.25	511	0.40	1.04	15	23.51	1.64
Berkshire Hathaway Inc.	NYS	15550.0	-3.15	32.34	16200.0	8875.00	1	0.00	0.00	42	6437.25	2.42
Chandler Insurance	OTC	3.75	-9.09	-21.05	7.63	3.50	2	0.00	0.00	13	8.63	0.43
Chubb Corp.	NYS	81.75	-4.39	-8.02	96.38	68.00	1865	1.72	2.10	12	40.67	2.01
CIGNA Corp.	NYS	58.38	-0.43	-0.43	68.00	47.13	461	3.04	5.21	11	81.73	0.71
CNA Financial Corp.	NYS	92.13	-0.67	-5.99	102.88	83.25	119	0.00	0.00	-13	80.24	1.15
Continental Corp.	NYS	28.50	-2.56	6.05	34.75	20.00	427	1.00	3.51	21	38.32	0.74
EXEL Ltd.	NYS	46.13	-3.66	-2.38	52.25	32.38	299	1.00	2.17	9	N.A.	N.A.
Fund American Corp.	NYS	82.75	-2.65	14.93	86.75	67.50	63	0.00	0.00	14	81.85	1.01
Fremont General Corp.	NYS	33.13	1.92	-3.99	41.75	19.88	58	1.08	3.26	8	25.62	1.29
Frontier Insurance Group	NYS	44.00	-3.56	1.15	49.00	30.25	25	0.60	1.36	14	13.97	3.15
Gainsco Inc.	ASE	14.00	6.67	-0.88	18.56	9.41	548	0.04	0.29	17	2.65	5.28
General RE Corp.	NYS	110.75	-3.38	-4.32	130.50	80.00	1256	1.88	1.70	16	46.07	2.40
Guaranty National Corp.	NYS	20.50	-2.96	3.80	24.00	14.38	128	0.48	2.34	12	9.12	2.25
Harleysville Group	OTC	26.00	0.48	-7.96	32.75	18.00	35	0.64	2.46	15	16.77	1.55
Hartford Steam Boiler	NYS	53.25	-4.27	-7.79	59.88	51.50	100	2.12	3.98	20	19.74	2.70
HCC Insurance Holdings	OTC	22.38	9.82	10.49	23.50	12.25	93	0.00	0.00	23	10.12	2.21
ITT (Hartford Group)	NYS	81.38	-3.13	13.02	85.13	62.50	716	1.96	2.41	-35	68.23	1.19
Kemper Corp.	NYS	33.25	-3.62	12.24	43.00	20.75	885	0.92	2.77	-8	37.66	0.88
Lawrence Insurance Group	ASE	6.50	6.12	-24.64	10.25	5.50	3	0.12	1.85	-	4.66	1.39
Liberty Corp.	NYS	29.00	-1.69	2.65	33.88	25.00	79	0.56	1.93	12	18.43	1.57
Lincoln National	NYS	75.00	-2.28	2.56	83.63	58.38	414	3.04	4.05	10	58.92	1.27
Markel Corp.	OTC	35.50	2.16	13.60	36.50	23.00	45	0.00	0.00	11	20.24	1.75
Mutual Risk Mgmt. Ltd.	NYS	32.50	-7.14	-19.75	46.00	25.75	125	0.28	0.86	18	7.51	4.33
NAC Re Corp.	OTC	35.13	-1.75	-13.27	44.75	21.75	277	0.16	0.46	49	13.60	2.58
National Re Corp.	NYS	32.38	-5.47	9.28	39.63	17.63	155	0.12	0.37	12	N.A.	N.A.
Navigators Group	OTC	34.50	4.55	6.15	36.00	28.50	23	0.00	0.00	25	15.69	2.20
Nobel Insurance LTD.	OTC	7.06	0.90	20.22	8.25	4.25	82	0.00	0.00	3	3.91	1.81
NWNL Companies	NYS	29.38	0.43	-42.26	32.44	17.25	454	0.80	2.72	13	46.21	0.64
Ohio Casualty Corp.	OTC	63.50	-0.78	0.59	68.75	53.00	271	2.64	4.47	12	43.08	1.47
Old Republic Int'l	NYS	22.13	-3.80	-11.06	27.38	19.50	366	0.44	1.99	7	18.63	1.19
Orion Capital Corp.	NYS	37.63	-5.64	6.36	46.38	26.69	94	0.80	2.13	8	28.62	1.31
Phoenix RE Corp.	OTC	26.50	-10.17	68.25	34.00	9.00	669	0.20	0.75	-58	13.32	1.99
Provident Life	NYS	27.00	-0.46	-5.26	31.50	21.00	66	1.04	3.85	10	30.38	0.89
Re Capital Corp.	ASE	14.88	-1.65	-9.85	16.63	12.25	3	0.28	1.88	30	16.88	0.88
Reliance Group Holdings	NYS	6.63	-5.36	8.16	8.50	4.25	260	0.32	4.83	3	2.94	2.25
RLI Corp.	NYS	25.88	-0.48	4.55	28.63	18.75	9	0.52	2.01	12	17.92	1.44
St. Paul Companies	NYS	79.25	-2.01	2.92	83.25	67.88	201	2.80	3.53	-13	59.79	1.33
SAFECO Corp.	OTC	56.63	-3.41	-0.22	66.75	48.38	2291	1.80	3.18	13	35.37	1.60
SCOR U.S. Corp.	NYS	16.25	-5.11	-7.14	20.75	13.13	14	0.32	1.97	203	14.39	1.13
Seibels Bruce Group	OTC	0.88	-17.69	-53.33	6.13	0.38	22	0.00	0.00	-0	6.22	0.14
Selective Ins. Group	OTC	23.75	4.40	7.95	25.75	19.00	122	1.12	4.72	13	20.22	1.17
Statesman Group Inc.	OTC	11.50	-2.13	-4.17	16.50	5.00	298	0.20	1.74	6	6.71	1.71
TIG Holdings	NYS	23.00	-6.12	N.A.	26.50	23.00	1639	0.00	0.00	-8	-	-
Tokio Marine & Fire	OTC	62.75	-1.57	30.73	64.50	36.75	3	0.00	0.00	-	70.93	0.88
Torchmark Corp.	NYS	53.00	-4.07	-6.61	64.75	41.16	522	1.04	1.96	14	14.87	3.56
Transatlantic Holdings	NYS	49.63	-1.98	-11.58	56.75	29.38	78	0.28	0.56	16	21.85	2.27
Traveler's Corp.	NYS	28.63	-3.38	5.05	30.75	17.13	879	1.60	5.59	-4	43.85	0.65
Trenwick Group Inc.	OTC	42.00	-2.89	3.07	49.75	26.00	119	0.88	2.10	15	23.87	1.76
United Fire & Casualty	OTC	37.50	3.45	-9.64	43.00	35.00	0	1.00	2.67	87	28.47	1.32
Unitrin	OTC	43.25	-1.70	1.17	46.75	32.75	355	1.20	2.77	14	36.51	1.18
UNUM Corp.	NYS	52.00	-2.12	-1.89	58.38	38.13	740	0.80	1.54	14	21.83	2.38
US Facilities Corp.	OTC	9.75	-2.50	-2.50	11.50	6.50	252	0.00	0.00	13	9.64	1.01
USF&G Corp.	NYS	16.38	-3.68	32.32	19.63	9.88	795	0.20	1.22	-	10.29	1.59
USLICO Corp.	NYS	18.13	0.69	0.69	20.00	15.00	27	0.24	1.32	-6	29.80	0.61
USLIFE Corp.	NYS	39.13	-1.88	7.93	42.63	29.34	93	1.20	3.07	12	64.90	0.60
Washington National	NYS	23.38	-6.50	1.63	28.00	19.25	68	1.08	4.62	13	30.27	0.77
Zenith National Ins.	NYS	23.63	-3.08	19.62	29.25	16.38	30	1.00	4.23	20	14.81	1.60
Zurich Reinsurance Centr.	NYS	31.50	-1.95	N.A.	36.38	31.25	592	0.00	0.00	-	23.99	1.31
INSURERS/REINSURERS	AVERAGE		-2.0	3.6					2.0	15.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	27.00	2.86	35.00	29.00	14.50	878	0.00	0.00	25	9.61	2.81
Pacificare Health Sys.	OTC	39.25	-2.18	-23.04	57.50	25.50	43	0.00	0.00	20	3.90	10.06
Safeguard Health Enter.	OTC	8.75	-5.41	-10.26	12.25	7.00	12	0.00	0.00	11	4.03	2.17
Sierra Health Services	ASE	16.00	-8.57	-26.01	21.69	8.06	177	0.00	0.00	14	2.01	7.96
TakeCare Inc.	OTC	39.50	0.64	-11.24	50.25	25.75	325	0.00	0.00	15	2.01	19.65
United Healthcare Corp.	NYS	57.00	1.79	0.22	68.00	37.75	1148	0.03	0.05	31	4.68	12.18
United Medical Corp.	ASE	9.38	0.00	47.06	9.75	6.13	0	0.20	2.13	17	10.30	0.91
U.S. Healthcare	OTC	46.75	5.65	4.76	59.75	29.34	4896	0.52	1.11	23	3.60	12.99
Wellpoint Health Networks	NYS	27.75	-3.06	N.A.	39.75	23.00	489	0.00	0.00	15	-	-
HMOs	AVERAGE		-0.9	1.8					0.4	19		
ALL COMPANIES	AVERAGE		-1.5	1.8					2.1	18		

System design: Nordby International Inc.

PROTECTION FROM A DIFFERENT PERSPECTIVE.

A perspective on business insurance that comes from a combination of international roots with national presence. Strength and stability with experience and innovation.

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Royal Insurance

YOUR SHIELD AGAINST THE UNEXPECTED.